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MENTAL HYGIENE

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A BIOLOGICAL PERSPECTIVE FOR EDUCATION DURING PERIODS OF SOCIAL CHANGE *

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SIX years ago a man married and took his wife to live with his mother. Two children were born. Just before the birth of the first child, the man became unemployed and "the family went on relief." Several weeks ago the wife secured a W.P.A. job and on the day when she received her second pay check, deserted her husband, the two children, and her mother-in-law. What were the forces at work? Were they emotional, social, industrial, economic, or political? We are often wont to look upon events in the emotional, social, industrial, economic, or political spheres as distinct from one another and motivated by forces contained within their individual energy systems; or we may be somewhat more flexible in our thinking and recognize that what takes place in one energy system may directly or indirectly affect the course of events in another system. Abstract terms are useful to indicate that discrete human episodes may be classified under diverse headings. Yet in actual living these events succeed one another without regard to the classifications into which they may fall. Segregation of human behavior according to abstract frames of reference which are based upon secondary and tertiary attributes may obscure our thinking more than it clarifies it.

Let us consider our case illustration, and we will see that political, economic, industrial, social, and emotional factors

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were all present. The successive items of human behavior are quite clear and lead to equally apparent changes in human relations. It is, however, much more difficult to determine whether the forces related to the unemployment, the relief, the new job, and the pay check were in whole or in part social, industrial, economic, or perhaps even political. The one thing of which we can be certain is that if we inquired further into the unemployment, the relief, the new job, or the pay check, regardless of how we labeled them, we should trace back a series of human events from one human relationship to another. We should discover that people approached each other, communicated, did some service, or exchanged some commodity. We could either follow the commodity and learn some of the conditions under which it was transmitted from person to person, or we could follow one of the individuals in the transaction as he sought out a succession of other persons. Thus we should see a curious spectacle of human beings endlessly going from one to another—now intently concerned with this one, now completely occupied with that one. Each does not go his own seclusive way and yet neither does he move as a unit of an undifferentiated horde.

As we observe more closely these "comings and goings" of human beings from one to the other, we are impressed with the apparent earnestness of the activity. Seldom do these contacts take on that casual quality that might be attributed to chance or accident. On the contrary, there appears to be a direction to their action. It is as if each were an organization functioning separately, but influencing and being influenced by other units with which it enters into relationship. In this interweaving of life patterns, we are faced with two problems: first, how each individual came to express himself through his own particular form of behavior; and second, what biologically dynamic principles underlie the traffic that takes place between individuals. It is the latter problem that is the more important for our present discussion.

II

Some animals go through their life cycle with little significant contact with other members of the same species, while in other species any action of one member could be relevantly described in terms of its relationship to some

other of its own kind. What is the meaning of these differences and on what bases do they arise? The differences in behavior patterns between species would seem to be related to certain of their biological needs. For example, the brooding habits of each species of bird must bear a relationship to the temperature range within which their eggs are viable, or that species would soon become extinct. Similarly the behavior patterns of ants and bees must be such as to guarantee the protection of the larvæ during the vulnerable period. All mammals are born relatively helpless and most would perish if it were not for their parents' protection. Besides the general inability to procure their own food, there are varying degrees of helplessness, due to relative blindness, inadequate means of locomotion, and inability to protect themselves from the natural forces and enemies that surround them.

The quality and degree of the offspring's helplessness vitally determine the detail of the parents' complementary protective patterns. When this complementary relationship fails, survival of the individual or of the species is threatened. This biological relationship, together with the mutual interdependencies implied in sexual reproduction, constitutes the primary force operating toward the development of animal societies. Furthermore, the quality, degree, and duration of infantile helplessness seem to be the potent influences upon animal societies, since they determine many of the details of reproductive interdependencies, which in turn bear a positive relationship to the kind and degree of the group's social organization. In other words, extreme helplessness of offspring is positively related to extreme social interdependencies, especially within the family unit, and generally, when the helplessness is of prolonged duration, it carries over into extra-familial interdependencies.

Why the interdependencies between members of the species continue after the stage of helplessness is passed, is a nice question. Some light is shed upon the problem when we observe that the greater the helplessness of the offspring, the greater is the complexity of the social organization, the more there is specialization of function, and the better developed are means of intercommunication by touch, visual signals, or by sound. It would appear that the greater the helplessness of the offspring, the more markedly must adult

patterns of behavior be adapted to meet it and the more do interdependencies among the mature members become characteristic of the species. Perhaps this is necessary in order that adequate parental attitudes may be available for the helplessness of the offspring, or perhaps it is that the greater the helplessness of the offspring and the longer its period of dependency, the less the likelihood of its ever completely abandoning its dependency upon other members of the species. Whatever the sequence may be, it does appear to be a fact that the greater and the more prolonged the helplessness of the offspring, the more complex and the more persistent are the interdependencies found among the mature members of the species. This is true to an extent that causes us to believe that social organization among animals can be fully understood only if this biological perspective is included and the survival value of interdependency among the members of the species kept clearly in mind as the most significant characteristic of a formed society.

When human society is approached from this point of view, we note the extreme and prolonged helplessness of the human infant, with the complementary complex organization of the human family, its specialization and division of function going hand in hand with a degree of interdependency that is unique among animals. Furthermore, one can see these interdependencies extending outside of the family in the form of coöperative, collaborative efforts which permeate every phase of our social, economic, industrial, and political life and determine such of its attributes as are cohesive and mutually facilitating. Without human interdependencies, man could not survive and society could not have developed nor could it continue.

III

Individual competition for survival is another biological principle that must be taken into account if the detailed patterns of animal societies are to be understood. While interdependency is related to survival of the species from generation to generation and to competition between one species and another, competition or rivalry, as we propose to use the term, would refer to the struggle for survival between individuals of the same biological or social unit. We would

think of extending the meaning to include struggle between units only to the extent that it can be shown to influence the survival of the individual. We would include under this concept not only the battle for the retention of individual life, but also efforts to secure and retain such strategic locations, powers, and prerogatives as would tend to place the individual in a more favorable position or would enhance his resources with respect to current or prospective contests. In the practical application of this term to human affairs, we would include the striving for sexual objects, property, position, prestige, personal achievement and prerogatives, and for the love, affection, and interest of friends, both in so far as they are socially valued and to the extent to which they directly or indirectly support the position of the individual for his own survival and that of his offspring.

Within a large section of our population, there is a tendency to see competition entirely from an ethical standpoint and to condemn it as bad because under special circumstance and in its more ruthless forms it may have seriously destructive effects. Associated with this is a strong disinclination to recognize a competitive factor in any development or achievement that is ethically commendable. However, it is our opinion that, whether good or bad, a competitive factor is implicit in any social relationship, since it constitutes one of the essential characteristics of biological existence. Because of the destructive quality of certain of its aspects, we often need to deny its presence, in striving for goals that are commendable and unselfish. Nevertheless, for our present purposes, we would propose that competition is good or bad depending upon the strategic position of the person who contemplates it, upon its goals, upon the secondary attributes and circumstances surrounding its manifestations.

IV

So far we have attempted to emphasize the hazard of reasoning about human behavior on the basis of abstractly conceived frames of reference unless a constant effort is made to check the process by observations of actual human behavior and to relate our concepts to biological origins. With this warning in mind, we have already endeavored to develop the concepts of dependency and competition and to show that

they are closely identified with survival in the face of biological helplessness and are important in the formation of animal and human societies.

It would seem that neither human society nor human relationships can take place without dependency and competition. Instead of being mutually exclusive, these two paradoxical principles give social and human significance to all transactions between individuals, the form and outcome being influenced by the balances existing between them—*i.e.*, the degree and kind of dependency of each upon the other as well as the effects of their respective competitive positions upon the transaction. Furthermore, competition and rivalry generally imply a striving for some object or person with respect to which each is in need and dependent.

We have used the adjectives "social" and "human" frequently in our discussion. It would seem wise to clarify the distinction between social conditions and human relationships. Now the only facts that can be observed and studied are episodes that take place between two or more individuals. So it would seem that these terms refer to different ways of viewing or describing the same phenomena. The latter emphasizes the nature and the course of inter-reactions between individuals, whereas the former refers to these same inter-reactions considered within the framework of the total group, with special cognizance of their incidence. However, the terms "social conditions" and "social changes" carry an additional significance which the term "human relations" does not. We refer to social institutions and organizations, with their laws, rules, regulations, and conventions. These constitute, as it were, the rules of the game of human relations, which have grown out of the pain of interdependency and competition and are imposed upon the group either by common consent or by one or more competitively dominant individuals.

These rules and conventions give society an implied abstract existence. Their practical impact upon human relations, however, is quite indirect. The violation of them carries with it a threat that many potential rivals will rally to the cause of the competitor most immediately concerned. If this actually occurs, then the competitive position of the violator is seriously jeopardized or actually destroyed. However,

even when the threat of these rules or conventions effectively prevents their violation, dependency and competition have not been eliminated. It is merely that a new and complicating factor has been introduced of which the individual can take advantage according to his personal ability or need, and in this way it is he himself who modifies his own relationships.

Let us return again to the deserting mother who secured a W.P.A. job. Following a long series of industrial, economic, and political episodes, the government recognized the dependency of a large group who had been all but destroyed through industrial competition. At first financial relief was provided, but, fearing that dependency would be increased and competitive effectiveness weakened or even destroyed, a policy of made work for pay was substituted in its place. During the period of public financial relief the human relationships within the family we are considering remained unchanged, each member being dependent upon the government.

With the political shift to made-work relief, the man and the woman came into competition. The woman was the first to win a more favorable position. Whether she should or should not have done so, she was now able to cast off any need to vie with her mother-in-law for her husband and her children, nor did she need to carry them as a dead load in her economic and sexual competition with other women. Through her being able to cast off her family's dependency upon her, their dependency upon one another was increased. The whole dynamics of the family changed, and the ideals and feelings about wife, mother, daughter-in-law took on new meanings for those who were left behind. Thus we see that the problem of the competitive-dependency status brought a change in government policies and that this in turn destroyed the existing relations of each family member. The mother-in-law no longer needed to compete with her daughter-in-law for her son. She could now be more dependent upon him and he upon her. The husband could no longer be dependent on his wife. In so far as he previously had been, he must now turn to his mother. In the rivalry between the children, the father and the grandmother will now alone set the rules, the forfeits, and the gains. It is also on them that the children must now depend for solace and help in their minor daily problems.

But why did the mother start all this? She had always been envious of (wished to compete with) and easily influenced by (dependent upon) her sister. Later, "sisterlike" friends shared these powers. One such friend had deserted her husband and had told her what a fool she was to waste her life as she did with children, a mother-in-law, and a good-for-nothing husband. Thus the husband was in competition not only with his wife for a job, but with her friend for the possession of his wife.

We recognize that each of the five individuals in this family has a dependency upon one or more persons and that each is involved in a competitive situation, regardless of whether their drives are effectively marshaled with respect to it. Closer scrutiny would reveal that each of them has his or her individual patterns of behavior which repeatedly involve them in special kinds of dependent relationships and which determine their competitive conduct. Certain kinds of dependencies may handicap, others facilitate, the individual in his competitive struggles. Moreover, complementary dependency reactions will be called out when certain types of competitive situation are precipitated by another. For example, a young boy, fearful of his adequacy to cope with the challenge of the neighborhood bully, may fall back on the support of his gang or his father, or seek the comfort of his mother, according to the developmental stage of his dependency and competitive reactions.

Let us summarize this by means of two generalizations: first, each of us has his individual dependency and competitive behavior patterns, which are called out and influenced by the nature of the situations in which he finds himself; and second, each one's dependency and competitive patterns are interrelated in a complementary manner. The details of the latter determine the kinds of social situation in which one can survive and be happy and comfortable. They will also be one of the general factors defining the types of social situation and relationship one will seek. There are, of course, other determining factors, such as personal goals, ideals, appetites, and ambitions. All of these, however, have a common background in the impulses arising out of the demands of bodily form and function, the details of which have been modified

by life experience, including the dependency and competitive relationships passed through during the course of individual development.

V

With this in mind, let us turn to a consideration of recent social changes. If we ask ourselves the question, "What leads to social change?" we will generally find some such dynamic sequence—a strong protest on the part of individuals who are pained by the impact of existing social practices, an insidious change in human relationships on the part of these protesting individuals. Gradually this develops a characteristic pattern, and the incidence increases until it becomes a social problem. There then follow social tensions and more sharply focused and conflicting protests, which are resolved by general changes in the conventions. More briefly, the pain caused by certain social demands of others gives rise to protest, at first individual, but gradually becoming more generalized until the details of human relations become modified at these particular points. The changes themselves become crystallized into conventions, having once more the power, through social pressure, to effect further changes.

Thus the link between social changes and changes in human relations, both of which continually act and react upon each other, is the protest of individuals threatened by the mixed dependency-competitive situations in which they find themselves. For example, an industrial laborer may find himself completely dependent upon an employer for money to buy food. Further, as he observes the more favorable gains of others, he may develop dissatisfaction and, helpless in his rivalry with his more powerful and strategically situated employer, he turns in protest to other workers, with whom he may make common cause. If numbers can be rallied, two things happen. First, the original competitive situation between the workers is replaced by a special and complete dependence upon each other. Second, energies which have formerly been devoted to competition between them are now directed against the employer toward whom they are individually helpless. Should collective bargaining evolve out

of this modification in human relations, then a social change resulting in a new convention or law would take place. Hence the nature of the interdependencies between worker and employer and between worker and worker would change and the conditions under which competition could take place would be altered. Each must modify his original practices and attitudes if survival and a happy and comfortable state are to be achieved.

As we consider the social changes that have occurred during recent years, it would appear that the details surrounding these two principles have been modified, but neither has lost its power or relinquished its significance for survival and happiness. Even though our social life has become more complex, we still find that we must come to terms with both horns of this dilemma in each new human relationship, whether it be purely personal, domestic, industrial, economic, or political in its significance. In the past, dependencies, with their implied loyalties, and rivalries, with their implied loves and enmities, were usually laid down for the individual's personal, domestic, social, industrial, economic, and political relationships, respectively, as a permanent part of the situation in which he found himself. In addition, these various aspects of life were more firmly bound together, since his basic family origin was more crucial in delimiting the nature of the conditions under which his life would be lived. He was more or less born into a set of firmly fixed dependencies and rivalries which permanently circumscribed his functioning. With the advent of rapid transit, rapid communication, and industrial expansion, these earlier rigidities have in part broken down. The increasing diversity of opportunity now brings to each individual, in so far as his emotional organization will permit, a wider range of choice and conditions for new relationships. The family, as self-sufficient for survival, and the patriarchal type of isolated industrial unit have passed. For example, the power of the industrial executive may now be effectively challenged at many points—at his source of raw material, by his banker, his stockholders, his workmen, his customers, or his competitors. Although he is still in a strategic situation, his dependencies are more immediately apparent and complex. This change holds true for

leaders in the economic, political, and professional phases of life.

The shift within the family is equally striking. Biologically the family, as the basic reproductive unit, is concerned with the relationships between the two sexes, and assumes the principal responsibility for the rearing of children. As such it is the primary social unit. It has also been an economic and industrial unit. Until the recent past it has been able to perform its biological and social tasks fairly adequately. As long as the family was the principal economic and industrial unit, or as long as the original family situation determined in general their social, industrial, economic, and political situations, children were reared in a setting which was nearly identical with that in which they were later expected to function as adults. Hence the dependency and competitive patterns developed in adjusting to the family during childhood would tend to be appropriately effective throughout life. Such changes as did occur were slow and slight. But with the radical industrial and economic changes of the last two generations, the functioning of the family has been markedly altered. There is grave doubt whether the family, with its biologically determined dependency and competitive situations, is raising its children to meet adequately the chaos of dependency and competitive situations that will confront them outside of the family as adults. Part of this apparent failure is due to the fact that the child is raised in a situation where one set of conventions is supposed to hold, while later he finds himself in a life situation where a totally different set of conventions holds. For example, within the family the child is supposed to be free from envy, jealousy, and strong competitive drives, with the result that his initiative, aggression, and ingenuity are sadly cramped. When he becomes an adult, his competitors heartily approve this handicap since it renders him powerless against them. Peace within the family and survival outside of it would seem to demand somewhat contradictory patterns.

Another reason for the present criticism of the family is that it has not as yet readjusted to the impact upon it of these many external changes which have brought about secondary alterations in the husband-wife and parent-child relation-

ships. The biological foundation of the family structure is all that remains unshaken. When the industrial center was shifted from the family circle to the urban industrial arena, the complementary industrial specialization of man and woman, with its mutual interdependencies, was seriously disturbed, until now one commonly sees husband and wife competing with each other in shops and factories far removed from their mutual family abode. Children may no longer see their parents as a typical father and an idealized mother. A third type of hybrid parent is clearly discernible—an anomalous half-mother and half-father of either sex. A generation ago, one seldom asked who "wore the trousers"; in recent years it may be either father, mother, son, or daughter. The old patriarchal balance of power within the family is all but lost, unless Dr. Townsend can have his way. The old dependency and competitive patterns are curiously twisted into new and unfamiliar forms which as yet seem to leave few persons sure of anything or really comfortable.

It was the old tradition that sexual competition was an active part of courtship leading to marriage. After the binding ritual, all competition was ended. Upon each mate devolved the burden of protecting the married partner from the remaining latent competition of members of the opposite sex. That this mystical agreement insured the continuity of marriage, there can be no doubt, even though it may have lulled into silence emotional forces that often expressed themselves later in the guise of discontent and personal misery. In more recent years those who wish to continue to possess their mates must realistically recognize that sexual competition continues for an indefinite period after marriage, and that hazard can be avoided only if each can meet the dependencies of the other in a mature and satisfying manner, in addition to assisting each other in their extra-marital competitive situations. This is not a new demand for the continuity of marriage, but it is a marked shift in emphasis, which requires a much clearer and more complex awareness of what takes place from day to day both within and without the marital relationship.

When so much energy is of necessity focused upon the husband-wife relationship and upon outside competitive sit-

uations, little will be left for the increasing demands of child care. The wish for small families and reduced parental responsibility can be readily understood in the light of these changes. The former has been in part met by the rapid spread of contraceptive information and the latter by the shift of parental responsibility to public and private organizations. However, we see a large proportion of parents threatened and anxious to a degree that was rare a generation ago. On the one hand is the fear of being overburdened with parental responsibility when energies are already taxed by marital and extra-marital pressures, while on the other hand is the fear lest the school or other organizations for child care should steal their offspring from them. In the last decade parent-surrogate organizations have reacted by adopting programs well calculated to entice the child, while the parent is presented with wise counsel. It may be that many of these programs are better adapted to meet the needs of the child in a changing world than is the modern family. It is our present intent to describe rather than to evaluate. Out of this situation has arisen a variety of organizations for teachers and parents who propose to join hands in the interests of the child. It is difficult to conceive of a triangular relationship such as this without a rivalry creeping in which may as readily paralyze as facilitate their joint efforts. Often the available energies of both teacher and parent are absorbed in observing each other, sometimes to learn, often to criticize.

As soon as a child begins to form friendships in the neighborhood, the parent-child relationship ceases to be a completely closed corporation. Each new friendship is built as it were at the expense of the relationship to the parents. When in addition child-training and welfare organizations are baiting the child on the one side and the parents are investing so heavily in their marital and extra-marital relationships on the other, so serious a drain is placed upon the parent-child relationship that it becomes all but bankrupt. Home becomes rather like a parking station. Parental authority of a kind may still be there, but without the old-fashioned respect. Instead, we see the battle of wills, the rivalry for powers, privileges, and prerogatives beginning earlier, becoming more open and intense. So the paradoxical

position of the child, wherein he competes more seriously with those upon whom he is also dependent, inevitably increases his emotional conflict over divided loyalties, his rights, and what constitutes fair play.

There is another important aspect to this situation. In thirty years high-school enrollment has increased eightfold and college enrollment fivefold. This is a significant extension of the period referred to during which competition is taking place at something other than a stark reality level, since the youth is still usually under the protection of his dependency upon the parents. There can be little doubt not only that this will affect the nature of the human relationships during this eight-year period, but that it must also influence the youth's attitude in later life. We cannot generalize about what these effects may be, since each individual will take advantage and be influenced by these changed conditions in ways that are largely determined by his earlier character development, the nature of his conscious and unconscious phantasies and ambitions. However, we wish to digress for a moment to add that each youth has not only well-developed ways of behaving in this new dependency-competitive situation, but in addition all of his character traits are the end result of the impact between his innate potentialities and the dependency and rivalry experiences through which he has passed.

VI

What all of this may signify for the government of adults at one end and the education of children at the other, we cannot be sure, except that it emphasizes certain aspects of the commodity of human nature with which these institutions must deal. Whether human progress lies in the direction of more or less dependency or of more or less competition, can only be left to the future to determine. In government the trend on the whole has seemed to be in the direction of a definite recognition and acceptance of a more widespread though less intense interdependency, together with furtive attempts to redefine the goals for competition. In this country at least there are wide differences of opinion as to the merits of this change.

We have seen that the family is losing its former influence upon the child, relinquishing in part its rôle to outsiders who are justified, because of their special knowledge and skills, in assuming the prerogatives of parent-surrogate persons. For the child, this means an early and at times confusing shift in his dependency-rivalry strivings to the outside situation, wherein he must adjust to a succession of sibling- and parent-surrogate persons of a variety of types and under a wide range of different conditions. It is our opinion that to recognize these developmental processes and to help the child to achieve them through the acceptance of a mature and beneficent parent-surrogate relationship is the most important function of the school.

If we were to try further to define the task of education in this very unstable and changing world, we should say that its parental-surrogate function is threefold:

First, it should provide the setting best calculated to develop in the child an ability to adjust rapidly between the various levels of dependency upon others and the different kinds of dependability others may expect from him, as well as to exercise and develop him in realistically coming to terms with reversals in competitive positions similar to those he will of necessity face in his later life. All other educative efforts are of value in proportion to the facility he may acquire for maintaining that ever-shifting balance between these two series of behavior patterns necessary to meet varying personal and social demands without either crippling his effectiveness or sacrificing prized human relationships.

Second, it should foster that which is friendly in the child's relationships to parent-surrogate persons, in order that he may find through such friendships a spontaneous enthusiasm for some vocational activity that is in harmony with his subjective interests and capacities.

Third, it should endeavor to give each youth those curricular opportunities best calculated to equip him for effective work in his chosen field, not forgetting that cultural and avocational studies and experiences may prove to be of equal competitive and subjective value with vocational training.

Education is already undertaking this task, but it will succeed only in so far as it continues to experiment carefully

and to develop new pedagogical methods. Perhaps the principal advantage to be gained by considering the educational problem from this point of view is that it frankly indicates the tests that will later be applied by a mutually dependent and competitive society.

THE MANAGEMENT OF A SLEEP DISORDER: A DEMONSTRATION *

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BOOTH in out-patient department of psychiatric hospital. Doctor is seated at desk looking over case papers. Enter young girl patient.

PATIENT (*dejectedly*): Good morning, Doctor.

DOCTOR: Good morning, Miss Adams. I think you are looking better this morning, in spite of the fact that your chin is down to about the point mine reaches when I have just missed a five-dollar putt. I don't believe either case deserves such a long face. (*Smiles reassuringly.*) Please sit down. (*Patient does so.*)

PATIENT (*essaying a faint smile*): I'm sorry to look so tragic. I realize that I shouldn't expect to be cured in just a few days, and our discussions have already convinced me that I won't die, so I suppose I should try to cheer up. But I haven't slept a bit better and I feel lousy. It's no fun to lie awake and wonder.

DOCTOR: Of course it isn't. I've been through it myself. However, I have good news this morning. I have here (*scanning her papers*) a complete report of the physical findings in your case. Organically you are shipshape. Let's see, now. (*Looks at papers.*) Heart normal except for rapid pulse and slight irregularity. Lungs clear as a bell. Neuromuscular

* Adapted from "Sleep Disorders in Clinical Practice," by Franklin G. Ebaugh (*California and Western Medicine*, Vol. 45, pp. 5–9, 128–32, July and August, 1936) and presented at a faculty clinic, April 12, 1937, by members of the junior class, University of Colorado Medical School. The cast of the play was as follows: *Psychiatrist*, William A. Mayer; *Patient*, Helen L. Tepper; *2nd Patient*, Norbert L. Shere; *Colleague*, Frederick H. Good; *Nurses*, Mary Ellen Cully and Hilda Williams. Robert E. Rider directed the presentation. The play was one of the activities of the department of psychiatry. The present junior class has elected to give a similar demonstration.

system—hmm, nothing to complain about. Gastrointestinal system (*smiling*), stomach and intestines to you, pathologically negative. Genitourinary, negative except for a few very trivial and common divergences, which we needn't consider. That is a good report. We should be pleased.

PATIENT (*reluctantly*): Yes, I suppose we should be. Yet if those doctors are 100 per cent right and my heart is in good condition, why does it seem to flip around in my chest and palpitate so that it nearly scares me to death? They say my stomach is O.K. Then why do I feel so nauseated? Why do I vomit? Why is my stomach always so full of gas? Why can't I eat? I am led to believe that my lungs are tiptop. Then why in the world should I feel so fainty and breathless at times? And why, in the name of heaven, if I am such a fine physical specimen, can't I sleep? It's driving me crazy. I know you are sick and tired of hearing all my silly symptoms. I've recited the whole mess, together with all the intimate details of my personal history, to you so many times that I am rather sick of it myself. But what annoys me no end is that you probably think I just imagine about 90 per cent of these things. Well, maybe I do. But they certainly seem real to me. (*All this has been said with a good deal of sarcasm and some venom.*)

DOCTOR (*soothingly*): My dear girl, did I ever say I thought your complaints were imaginary? Of course they are real and unquestionably very distressing. I agree with you on that point. We may disagree, for the moment, about the causes of these disorders. When you complain of palpitation, it doesn't necessarily follow that you have heart disease. When you feel nauseated and vomit, it doesn't follow that you must have—well, gastric ulcer. Breathlessness doesn't prove that you have tuberculosis. I presume that you understand there is a distinction between organic and functional disorders?

PATIENT: I have heard the words used in connection with bodily ailments, but the distinction is vague.

DOCTOR: I'll try to clarify it. (*Pause.*) I suppose you drive a car?

PATIENT: Yes.

DOCTOR: Did the timing of your distributor ever become disordered?

PATIENT (*smiling*): I've no idea what you are talking about.

DOCTOR (*smiling*): I'm making a mental note to reserve that example for male patients. (*Pause.*) Let's see. (*Takes out watch. Points with pencil.*) Do you see that jewel bearing at the top of the balance wheel?

PATIENT: I do.

DOCTOR: Let's suppose that we get an accumulation of dirt underneath at the point where the shaft spins upon it. What happens?

PATIENT: The watch stops.

DOCTOR: Eventually, perhaps. First it is slowed because the function of the bearing is disturbed. Organically, let us say, the bearing is sound. It isn't cracked nor broken in any way, but the accumulated dirt produces a friction that was not anticipated by the builder of the watch; consequently the spring that furnishes the motive power proves to be incapable of overcoming that added resistance and the movement of the balance wheel is retarded. That wheel is geared to another, which in turn is connected to still others, thus making the mechanism an interrelated and interdependent whole. Because of this correlation the functional disturbances in the one bearing may extend to the whole mechanism, and the watch doesn't keep good time. But nothing is broken—the trouble is functional. Do you see the difference?

PATIENT: Yes, I see that.

DOCTOR: Now the human body is an infinitely more highly organized mechanism. All its organs and tissues and fluids are wonderfully integrated and sensitively correlated. Isn't it logical to assume that an accumulation of dirt—if we carry on the crude analogy—at some point could throw the function of the mechanism into disorder?

PATIENT: It seems reasonable. (*Pause.*) If, then, my organs are sound, the trouble must be functional.

DOCTOR: Exactly.

PATIENT: And at what point is the accumulation of dirt that causes my disorder?

DOCTOR: What do *you* think?

PATIENT: I'm sure I don't know. I only know that I feel restless and nervous and irritable.

DOCTOR: Would you say, then, that your emotional reactions were slightly exaggerated? So you become exasperated, shall

we say, by trivial things to an extent that is out of proportion to the cause.

PATIENT: I'm sure I do. I'm ashamed sometimes. (*Pause. Then, as if the thought had just occurred*) Can nervousness and irritability make my heart palpitate?

DOCTOR: Readily. There is a direct hook-up between that organ and the nervous system. Emotions send impulses of many kinds to the various body parts and greatly influence their functions. The vast physiological disturbances that acute emotions may induce are easily demonstrated in the laboratory. Take, for instance, the case of a badly frightened cat. We see such phenomena as the arching of the back, hair standing on end, dilated pupils, and so forth. More is going on inside the cat's body. The cardiovascular apparatus is energized and the blood pressure is raised. This increases the metabolism of the muscles; the increased pressure supplies blood to the muscles more effectively and sends a large supply to the brain, where quick decisions are made. Certain of the endocrine glands participate in this production of increased blood supply. The liver discharges more sugar into the blood, so that the muscles have more fuel for the mobilization of their energy. Respiration is more rapid. Stomach and intestinal movements, which would be a liability at this time, are at a minimum. So the net result is adequate physical preparation for a fight or flight.

PATIENT: It sounds rather terrifying. How can one bring these emotions under control so that the function of the organs will not be impaired?

DOCTOR: Mental attitudes are influential because thinking and emotional reactions are also interdependent. They act one upon the other often in an oscillating manner which sometimes forms a vicious circle. Thus any mental conflict may cause exaggerated emotional reactions, which in turn may cause physiological disturbances, which will produce insomnia and any or all of the symptoms from which you suffer.

PATIENT: Am I to infer that I am host to what you call a mental conflict? It sounds pretty bad.

DOCTOR: I suspect something of the sort. But it isn't bad and it isn't serious. You are an intelligent young woman, and I feel sure that we will have little difficulty in ironing out your

troubles, once they are brought to light and we gain a complete understanding of them. Now from what I have learned from our two previous interviews, I am led to believe that your principal complaint is sleeplessness. Is that right?

PATIENT: Yes. I feel that if I could sleep properly, everything else would right itself. I simply can't get along without sleep. I'm sure I'll have a terrible breakdown if I don't get more. I may even go insane.

DOCTOR: No, you won't. Sleeplessness doesn't produce insanity. And just why do you think you must sleep? Relaxation and rest will refresh you in both mind and body. The deleterious effects of loss of sleep have been grossly exaggerated. Many men have voluntarily deprived themselves of sleep, for experimental purposes, for periods covering from eighty to one hundred hours without any noticeable physical changes or decreased efficiency in the performance of varied mental tests. So long as these men kept active, they seemed to be as competent as they were during a normal day. One man deprived himself of sleep for ten days with no apparent ill effects. Aren't there many instances in history of men who combined great productivity with good health and longevity in spite of the fact that they slept only a very few hours out of each twenty-four? A few such come to mind. Napoleon, for example, and John Wesley, the founder of Methodism, and Thomas Edison.

PATIENT: Very well—suppose I should reconcile myself to very little sleep. I can't keep that up indefinitely, can I? I've got to get caught up sometime. It seems to me that eventually I would be so far behind in my sleep that it must have a serious effect.

DOCTOR: No, that is not true. Common sense indicates to us that there is no so-called "sleep deficit"—that is, that additional sleep is necessary to overcome the effects of prolonged loss of sleep. In the experiments I have cited, it was never necessary for the subject who stayed awake for one hundred hours to sleep subsequently for, say, thirty hours to get caught up. An ordinary night's rest would do the trick. You doubtless have experienced a similar thing on a smaller scale.

PATIENT: Yes, I suppose I have. But am I supposed to lie awake and like it simply because you tell me that sleeplessness won't hurt me?

DOCTOR: Naturally you don't like it, but the knowledge that it won't harm you may help you tolerate the condition and to that extent be assisted in effecting a cure. In the meantime we will try to dig out the cause. (*Pause.*) There are many disorders which bring sleeplessness. We may classify them rather simply as, first, environmental causes; then the psychobiologic causes, which include the toxic-organic causes and the personality malfunctions.

PATIENT: Those are big words.

DOCTOR: Big, perhaps, but understandable. The phrase, environmental causes, is self-explanatory, isn't it? In your case we have those causes pretty well eliminated. I presume you moved to the back room of your home, as I advised, in order to escape the noise of the trolley cars and autos of which you had complained.

PATIENT: Yes, I did, Doctor. And it is much quieter.

DOCTOR: Did you trade mattresses with your sister, so that you might have the spring-filled one?

PATIENT: She swapped with me—after an argument. She thinks I'm acting like a baby. I told her it was doctor's orders.

DOCTOR: Exactly. I'll be glad to talk with any member of your family if we find we need better coöperation. There are so many trivial things, particularly in the field of environmental causes, that will contribute to insomnia that it is essential to go over the field with a fine-toothed comb. You can do that and correct those things without my help.

PATIENT: I'll think the situation over carefully, Doctor, though I am inclined to feel that the seat of my trouble lies elsewhere. Comparatively speaking, I think I have a pleasant and comfortable place to sleep.

DOCTOR: You may be right. Yet these simple and obvious factors are never to be ignored. However, we will assume, then, that the trouble originates elsewhere. Now, of the psychobiologic causes, we have already eliminated the toxic-organic, by way of the negative physical findings. That (*smiling*) brings us up against some sort of personality malfunction, doesn't it?

PATIENT: I'm afraid it does—if the process of elimination has been complete. I suppose (*wearily*) I am a little queer—a trifle "teched in the haid," as they say in the funny papers.

DOCTOR: Not at all. All of us have mental conflicts of one sort or another.

PATIENT: And what is mine?

DOCTOR: Frankly, I don't know. At least not for sure. I can only know what you tell me about yourself. I have been trained to sort and evaluate that information. With that training, I can help you arrive at conclusions. It is a strictly coöperative venture.

PATIENT: When do we start?

DOCTOR: We have already started. In the course of our previous interviews we have studied your personal history and the details of your present illness with painstaking care. Would it be imposing too much upon your good nature to ask you to restate some of those facts?

PATIENT (*resignedly*): I'll be glad to if it will do any good. Shall I start again at the beginning?

DOCTOR: I think it unnecessary. You might start with the illness of your mother.

PATIENT: That was five years ago, as you know. I was eighteen, a senior in high school. Because of my mother's illness, I was taken from school in the spring of that year. I was unable to graduate.

DOCTOR: Did you mind that?

PATIENT: I was deeply disappointed. (*Pause.*) Has that some hidden significance?

DOCTOR: Very likely. Can't you see that it might?

PATIENT: I don't know the workings of the mind. I just felt resentful.

DOCTOR: Did you mind feeling that way?

PATIENT: I was ashamed of myself for being resentful. My mother needed me. (*Pause.*)

DOCTOR: Continue, please.

PATIENT: Well, as I have told you before, the next four and one-half years were quite uneventful. I simply stayed at home and cared for my mother.

DOCTOR: Did you like your job?

PATIENT: Job? Like it? (*Defiantly*) Isn't there such a thing as duty?

DOCTOR: To your mother? Yes. To yourself? Yes. In fairness shouldn't we say that our conception of duty might

vary, depending upon the point of view? Isn't it a relative thing? Isn't it a bit arbitrary for any one of us to say this thing is right—that thing is wrong?

PATIENT (*with thinly veiled disgust*): I am not a philosopher. I love my mother. Must I apologize for giving her the loving care that she deserves?

DOCTOR: Of course you love her, and that makes it difficult for you to observe the situation objectively as, for instance, I do. (*Pause.*) Tell me—if you had to work for a living, say in a factory, and you found that the work was undermining your health, wouldn't you feel that it was your duty to drop part of that work? Wouldn't it be your duty to explain the situation to your employer and ask him to lighten your labors?

PATIENT: It isn't a parallel case.

DOCTOR: It is except for the factor of sentiment involved. You have a sister at home and a father who can share your work with you.

PATIENT: Well, after all, who can say that caring for my invalid mother has made me sick?

DOCTOR: When did your illness begin?

PATIENT: I told you.

DOCTOR (*soothingly*): I know—but if you don't mind repeating?

PATIENT: It began about five months ago, when I went to visit my married sister in Kansas City. I became quite nauseated and fainty shortly after my arrival there.

DOCTOR: Why?

PATIENT (*echoing Doctor*): Why?

DOCTOR: Yes. Why at that particular time instead of, say, a few days before you left?

PATIENT (*slowly and thoughtfully*): Well, I really don't know, Doctor. I'm not very good at riddles. I can see that it was coincidental, but I fail to see any significance.

DOCTOR: I don't wish to imply that it is clear to me either. But it is something tangible for us to work on. *(Pause.)* How did you feel at that time about going away?

PATIENT: I felt like a dirty dog. Mother was quite unhappy over the prospect, but my sister wrote with such insistence that Mother finally decided to let me go. She cried when I left.

DOCTOR: Were you ill all the time you were away?

PATIENT: No, I stayed there for two months and except for those first few days I felt fine. Then when I returned home, I again became quite ill. I began to lose sleep. I fought the thing for about three months and then I came to you. That's about all there is to it.

DOCTOR: How did you feel about coming back to your mother?

PATIENT: Why—all right, I guess. Please, Doctor, my mother is not a horrible person. Frankly, I don't quite like your insinuations.

DOCTOR: I'm sorry. I mean no offense whatever, but we must face the facts in a sensible manner if we are to get you straightened out. You must be honest with yourself and with me. The beginnings of your illness seem to be hooked up in some way with certain events. Don't you think it would help us to solve your trouble if we pondered about those seeming coincidences?

PATIENT *(thoughtfully)*: I don't know. It might.

DOCTOR: Will you do that? Will you try to recall your exact mental attitudes on leaving and returning to your mother? Will you try to reason why you felt as you did.

PATIENT: Now?

DOCTOR: Not necessarily. At your leisure. It will take time to reconstruct it.

PATIENT: I'll do my best—though I hate thinking.

DOCTOR: Try to do it objectively. Stand off and observe yourself as another person. That may help us to get at the truth. *(Pause.)* Now one more question. Did your mother seem better upon your return from your sister's?

PATIENT *(annoyed)*: You asked me that in our last interview.

DOCTOR: I know. I'm sorry to be so repetitious, but some of these things may be important.

PATIENT *(contritely)*: I beg your pardon, Doctor. I'm afraid I'm not a very patient person—nerves all on edge. Yes, Mother seemed to be better.

DOCTOR: Did that please you?

PATIENT *(defiantly)*: Of course.

DOCTOR: Are you sure?

PATIENT *(slightly amazed)*: Why, naturally, Doctor. How else could a daughter react?

DOCTOR: Could you have felt a little resentful because your mother improved while in the care of others?

(Pause while patient thinks.)

PATIENT *(slowly)*: It is barely possible. I love her. I might be a bit jealous. We have been very close.

DOCTOR: Well, I think we can agree on one rather important point here—that is, that your mother can get along very well without you.

PATIENT *(reluctantly)*: I guess that has been shown.

DOCTOR: Fine! Then I want you to go to Kansas City again for another several weeks' visit with your sister soon. Can you do that?

PATIENT *(haltingly)*: I suppose so, if you order it. I guess Father and my kid sister can manage.

DOCTOR: I'm sure they can. In the meantime I'll see you again, say the day before you leave. Please call for an appointment.

PATIENT: Very well, Doctor. *(Starts to rise. Pleadingly)* But won't you please give me something to help me sleep? *(Sits down again.)*

DOCTOR: Frankly, Miss Adams, as I told you the other day, I don't think you need any medication. I'll tell you what—you try a warm bath for about forty-five minutes every night before you retire. Have the water at about body temperature and just relax. I'm sure it will help you quite a lot.

(Both rise.)

PATIENT: All right, that certainly won't hurt me any, and at least I'll keep clean. *(Smiles.)* Good-by, Doctor. I hope you are going to be able to help me—I rather think you will.

DOCTOR: Good-by, Miss Adams. Sleep well.

PATIENT *(smiling)*: I'll try. *(Starts to walk out.)*

DOCTOR: No, don't try.

PATIENT *(stopping)*: What do you mean?

DOCTOR: I'm glad you mentioned it. If you try to go to sleep, you will probably be defeated. Sleep can't be successfully wooed. We allow ourselves to sleep. Such well-known tricks as counting sheep and so forth are, therefore, worse than useless. Those warm baths are going to help you relax and then sleep will come. Besides, you are going

to have such a good time on your vacation that you may not want to sleep. *(Smiles.)*

PATIENT: I'm sure it won't be that exciting. *(Pause.)* I'll see you, then, before I go?

DOCTOR: Yes. Good-by. *(Doctor nods.)*

PATIENT: Good-by.

(Exit patient. Doctor sits down again and begins to arrange papers on his desk. Enter colleague.)

COLLEAGUE: Hello, Joe. About ready to go to lunch?

DOCTOR: Just about. Can you wait till I get things organized?

COLLEAGUE: I'm hungry. But I will. *(Then with friendly sarcasm)* I suppose you have just solved another baffling mystery.

DOCTOR: Well, not quite. But I think I am on the right track. And you needn't be sarcastic. It's just one of those simple cases that come to every doctor—girl with insomnia and accompanying symptoms—a careful search for the cause among environmental, toxic-organic, and personality-malfunction factors. You may find it all in one field or in a combination, which makes the problem tougher. With this particular girl, the trouble seems to be mainly situational—home in which she doesn't fit—demanding invalid mother—girl torn between what she thinks is duty to her mother and her conflicting desire for the normal outlets and activities of young womanhood. *(Smiling banteringly)* I think even you could work it out.

(During most of the ensuing conversation doctor can be busy sorting and filing papers. Colleague can sit on desk and lounge around in natural manner.)

COLLEAGUE: What's the treatment?

DOCTOR: Warm baths, removal from the situation, later complete aëration and explanation of the conflict.

COLLEAGUE: Sounds easy. Why don't you give her a little phenobarbital till you get her mental attitude straightened out?

DOCTOR: I don't think it is necessary. And I don't see any point in running the risk of building up a psychic dependency.

Anyway, I'd choose barbital. I believe it is a little quicker acting and more rapidly eliminated.

COLLEAGUE *(banteringly)*: That's you all over—always looking for an argument! How about some of the later barbituric-acid derivatives, such as sodium phenobarbital, neonal, ipral, propanal, dial, allonal, and amytal?

DOCTOR: Amytal is quick-acting, quickly eliminated, and has few toxic effects. But I'm inclined to go slowly on the newer ones. A fellow can't expect to have accurate knowledge of all the drugs that come on the market. I'd rather know a lot about a few.

COLLEAGUE *(banteringly)*: I think you are gradually getting more sense. *(Pause.)* Do you ever use any of the opium derivatives?

DOCTOR: Only for relief of intense pain or other standard medical indications. The danger of addiction is too great for use in chronic cases. I would rather use paraldehyde in cases where a powerful effect is desired and where moderate doses of the barbiturates are ineffective.

COLLEAGUE: Yes, but it tastes and smells like the devil.

DOCTOR: You can disguise it in iced orangeade. I like it because there is a wide factor of safety between effective dose and minimal lethal dose. Then there are few toxic effects, and it doesn't depress the heart and respiration. Besides, it is rapidly eliminated and the sleep is normal.

COLLEAGUE: But I've heard of a number of cases of chronic addiction to paraldehyde.

DOCTOR: There is some danger there, particularly in chronic alcoholism, where the patient has learned to tolerate the drug as he has alcohol. *(Pause.)* However, that can be watched. But you're a bright young man—why the devil do you choose to overlook hydrotherapy when you are searching for a treatment of insomnia?

COLLEAGUE: You're jumping at conclusions again, Joe—I'm not choosing to overlook hydrotherapy. I think it is very sound and practical. *(Smiling)* We may agree for once. I know that such treatment allays tension and promotes relaxation, but it takes equipment—special tubs, showers, pack sheets, and so forth.

DOCTOR: Any ambulatory patient can take a warm bath at home or have a sponging administered. For the rest, a

certain amount of equipment is needed, but these more drastic treatments have their greatest usefulness in the more severe psychiatric disorders which require hospitalization anyway.

COLLEAGUE: I'd like to see a cold pack given sometime.

DOCTOR: Be glad to demonstrate. I'll try to get hold of you in the near future when I have a good case. And remind me to show you some handy sleep charts we are using.

COLLEAGUE: I'll be interested. But I'm dying of starvation—let's shove off to lunch.

DOCTOR: I'm ready. Let's go.

(Exit both.)

SCENE II

Hospital room with delirious male patient in bed. Nurse is taking temperature, pulse check, etc. Enter doctor of Scene I.

DOCTOR *(to nurse)*: How is he to-night?

NURSE: He seems more disturbed, Doctor.

(Doctor observes patient closely, scans bedside charts.)

DOCTOR: I think I'll have you give him a cold pack, and see if that won't quiet him down.

NURSE: Very well.

DOCTOR: And by the way, will you please try to get hold of Dr. Bennett? He wanted to see one administered. I think you'll find him on his ward.

(Exit nurse. Doctor puts in time for a minute or two taking pulse, putting stethoscope on chest, etc. Enter nurse.)

NURSE: He's coming right over, Doctor.

DOCTOR: Thank you. You had better get some one to help you with the pack.

NURSE: Yes, Doctor.

(Exit nurse. Doctor continues to observe patient, or looks again at bedside chart, or tries to ask patient some questions. After a few seconds, enter nurse.)

NURSE: Miss Carlson will help me with the pack.

DOCTOR: All right.

NURSE: I'll go and be getting the materials ready.

DOCTOR: Please do.

(Exit nurse. Enter Dr. Bennett, colleague of Scene I. They greet each other in passing.)

COLLEAGUE: Hello, Joe. I'm glad you called me. What have you here? *(Looks at patient.)* He doesn't seem to know what it's all about.

DOCTOR: No. Delirious. Take a look at his sleep chart. *(Hands colleague the small bedside chart to scan.)* You can see why we are giving him a pack.

COLLEAGUE: Yes, lots of white spots. It's a very graphic way of presenting the record.

DOCTOR: Quite so. They were devised at Phipps Psychiatric Clinic. We leave them on the ward and the nurse fills them out at half-hourly intervals. Soon as we finish the pack, I'll bring in some of the large ones we use in the lecture room and show you some typical patterns. I may even throw in one of my lectures. *(Grins.)*

COLLEAGUE: All right, professor, if you insist. I can take it. *(Pause. With friendly scarcasm)* Maybe I can tell you something. I've followed a few cases in which there has been sleep disturbance resulting from toxic-organic disorders. I didn't find any two alike.

DOCTOR: Well, that seems reasonable since the content and toxins make sleep very difficult. Your chart will be spotty and of no characteristic pattern. However, even if it isn't of much diagnostic aid, accurately kept charts will show you at a glance that sleep is deficient and will guide you in changing the medication or prompt you to prescribe a more effective treatment, such as a cold pack, when it is most useful.

(Enter nurses with materials for packs.)

DOCTOR: Here we are.

2ND NURSE: How do you do, Dr. Bennett?

COLLEAGUE: Hello, Miss Carlson. Haven't seen you for quite a while.

2ND NURSE: No. How's everything going in your department?

COLLEAGUE: Fine, thank you.

(Nurses administer pack in businesslike manner. No set dialogue seems necessary for this episode. It is suggested that the nurses instruct the patient and each other in a nat-

ural way as required in the application of the pack. Doctors watch the process interestedly and may make fragmentary comments if anything apt occurs to them. The patient complains loudly at first and gradually subsides somewhat.)

COLLEAGUE *(to nurses, when pack is completed)*: That was well executed. You seem to have done it before.

NURSE: Thank you, Doctor.

DOCTOR *(to nurse)*: I believe I'll have you move him to the ward with those other two, so that you can watch them with less trouble. Please report anything out of the ordinary to me.

NURSE: Of course, Doctor.

DOCTOR *(to colleague)*: Now, Doctor, if you can spare a few minutes more, I'd like to show you those big charts.

COLLEAGUE: I'm in no hurry.

(Exit doctor. Nurses start to wheel bed off stage.)

COLLEAGUE: Good night.

NURSES *(not quite in chorus)*: Good night, Doctor.

(After few seconds, enter doctor with charts. He leans them against a convenient table or chair.)

COLLEAGUE: Say, how long will it take that fellow to quiet down? He didn't seem to like it.

DOCTOR: He'll be as quiet as a mouse in fifteen or twenty minutes. The time required for sedative action varies, of course, depending on the state of disturbance. Patients naturally don't enjoy the initial contact with the cold sheets, and apprehensive persons should have the procedure explained to them beforehand. But the soothing and sedative effect comes quickly, and once they have experienced it, they have no fear whatever.

COLLEAGUE: Isn't there some danger of shock?

DOCTOR: There is, due to the strong initial vasoconstriction, and patients with vascular damage must be watched. But ordinarily there is nothing to fear. With the cold douches and sprays, we must be more careful.

COLLEAGUE: Well, I see you have your charts. Are you ready to start your lecture? *(Smiles.)*

DOCTOR *(placing charts where audience can see them, with that of psychoneurotic in front)*: Ready—even eager.

(Smiles.) You see, in mental disorders we get some rather characteristic patterns—patterns that you perhaps don't find in your toxic-organic disturbances. Now in this graph, for instance *(pointing to chart)*, which is that of a psychoneurotic patient, you can see by the preponderance of white spaces on the left side that the patient has great difficulty in going to sleep. Then it is intermittent. The preponderance of black on the right *(pointing)* shows that after he once gets started, he does very well and is inclined to prolong it far into the morning.

COLLEAGUE: What keeps him awake so long?

DOCTOR: Here it is the content—a mixture of anxiety and fearfulness, with a hypochondriacal tinge.

COLLEAGUE: Is the pattern typical of the whole group?

DOCTOR: Fairly so. Consequently the graphs are of some diagnostic aid.

COLLEAGUE: Did that girl you were telling me about in the out-patient clinic a few weeks ago fit the pattern?

DOCTOR: I didn't keep a chart on her, but from what she told me, I think I can safely answer yes.

COLLEAGUE: How is she getting along?

DOCTOR: Much better, I think. I sent her away to her sister's for a change and rest. Had a note from her yesterday. She's coming back. I'll see her in a day or two.

COLLEAGUE: Do you think you can reëducate her so that she can tolerate her domestic situation better?

DOCTOR: I hope so. She's an intelligent young woman. I saw her again the day before she left, and she seemed to begin to understand the nature of her conflict.

COLLEAGUE: In handling a case of that sort, do you try to explain to her why she doesn't sleep?

DOCTOR: I try to have her explain it to me. It's a rather tedious process, but more convincing and more effective.

COLLEAGUE: We are digressing. First thing you know, we'll be talking about golf or trout fishing. *(Smiles.)* On with your lecture.

DOCTOR: All right. *(Puts rear chart in front.)* This is a graph of a patient in a simple depression. As you can see, it is just the reverse of the first. The black here *(pointing)* shows that he has no difficulty in going to sleep. Then he

wakens in the early morning hours, as you see, and the typical melancholic ruminations prevent a return to sleep.

COLLEAGUE: Is that pattern sufficiently characteristic to be of diagnostic aid?

DOCTOR: Only as an adjunct. Together with sadness and melancholy, this type of sleep may be considered as pathognomonic of depression.

COLLEAGUE: What sort of sleep picture does a person in a manic state present?

DOCTOR: No definite pattern. Elated moods will show all types of disturbance. A patient in such condition may not sleep at all because he is too busy with his ideas and plans.

COLLEAGUE: This phenomenon called sleep is a strange thing, isn't it?

DOCTOR: It is, indeed. What causes it?

COLLEAGUE: Humph! You should ask me when better men than I am have been trying for years to find out.

DOCTOR *(smiling)*: Well, a fellow can ask.

COLLEAGUE: I have sense enough not to be dogmatic about it. It's rather hard to disprove any of the better theories, but on the other hand I can't think of one that has been proved to my satisfaction.

DOCTOR: It seems to me that Kleitman has assembled the best ideas from the various theories and presented them in the most understandable manner.

COLLEAGUE: What does he say?

DOCTOR: Well *(pauses)* he says that it's a conditioned phenomenon. It's a reversible activity of the highest functional centers of the cortex. Inactivity is produced by a functional break between the cortex and the lower centers. That break results in a decreased number of afferent impulses from the sensory organs, especially those of proprioception, which may become fatigued. Is that clear?

COLLEAGUE: Clear as mud. However, even if we don't understand the actual physiology of sleep, I suppose we all have to agree that it is a definite vital function engaged in by the personality as a whole, including all levels.

DOCTOR: Exactly. And therefore most sleep disorders must be treated on the level at which they occur—on the highest integrating or psychobiologic level.

COLLEAGUE *(starting to leave)*: I don't believe I should risk concentrating too much on such a profound subject when it is so near bedtime. *(Smiles.)* The ruminations might keep me awake.

DOCTOR *(banteringly, also starting to leave)*: You may flatter yourself. But if you would rather, I'll tell you about the grand slam vulnerable I made last night.

COLLEAGUE *(smiling)*: No, thanks. I'd be snoring before you had taken the second finesse. There's a treatment *you* have overlooked.

DOCTOR *(disgustedly)*: Phooey!

(Both exit while speaking the last few lines, doctor taking charts with him.)

SCENE III

Booth in out-patient department of psychiatric hospital, as in Scene I. Doctor is seated at his desk, waiting for patient. Enter patient of Scene I, smiling and cheerful.

DOCTOR *(rising and shaking hands)*: Well, hello there, stranger! Glad to see you back.

PATIENT: Thank you, Doctor. I'm glad to be back.

DOCTOR: It's no use for me to tell you that you look a lot better. You doubtless know it.

PATIENT: Yes, I feel so—definitely.

DOCTOR: Any recurrence of the old troubles?

PATIENT: Some when I first went away, same as before. A twinge here and there and a suggestion of nausea when I returned. But I managed to shake it off fairly well.

DOCTOR: Fine! How's the sleep?

PATIENT: Better, thank you. I'm continuing the warm baths at bedtime. Is that all right?

DOCTOR: Yes, if you feel restless. Skip them if you don't. Have you had a good time?

PATIENT: Grand! Got in a lot of good dancing. I love it. Then I took the opportunity to talk everything over with my sister. I tried to analyze my feelings in relation to my job, as you call it.

DOCTOR: Have you arrived at any conclusions?

PATIENT *(brightly)*: I know one of the answers.

DOCTOR: What is that?

PATIENT: I feel better and sleep better away from home.

DOCTOR: Why?

PATIENT *(slowly and thoughtfully)*: I'm not sure that I know just why. *(Pause.)* I suppose I'm happier maybe—in a way.

DOCTOR: In what way?

PATIENT: I don't mean to infer, Doctor, that I am particularly unhappy at home. But when I am away, I am able to do more of the things that I like to do. I go to more dances and movies—and such things.

DOCTOR: When you are at home, does your mother object to those activities?

PATIENT: I don't think she objects in the sense that you imply. She simply wants me to be with her as much as possible.

DOCTOR: But she seems to get along pretty well without you?

PATIENT: I guess she does.

DOCTOR: And you seem to get along better away from her.

PATIENT: I'm afraid I do.

DOCTOR: Why do you put it that way?

PATIENT *(thoughtfully)*: I suppose I mean that I feel a little ashamed because it seems to me that I am negligent of my duty. You know you asked me to try to remember how I felt when I left on the first trip to Kansas City? *(Doctor nods.)* Well, I believe that was my attitude.

DOCTOR: How about this last trip? How did you feel, when you left?

PATIENT: The same, I guess—though not so marked.

DOCTOR: And you were ill both times?

PATIENT *(smiling)*: I feel like a murderer on the witness stand, with all this cross-examination.

DOCTOR *(chuckling)*: I hope not. If you really do, then my technique is bad. I'm just trying to help you understand your emotional reactions.

PATIENT *(brightly)*: I'm beginning to feel that I know another one of the answers. You are working back to the case of the cat that was scared stiff. I leave my mother and I feel mean about it. That does something to my emotions, and my emotions do something to my insides, so I feel sick. Is that right?

DOCTOR: You are a very satisfactory patient. I think you are on the right track. It is very likely that your initial illness *was* precipitated by an exaggerated emotional state that was induced at that particular time by your intense feelings of self-condemnation. Do you think such feelings are justifiable if they tend to make you ill and unhappy?

PATIENT: It seems to me that under the circumstances it is rather natural to feel that way. *(Then petulantly)* I don't think you can expect me to view my duty as—a job in a factory. That's a hard, cold-blooded attitude—I think.

DOCTOR: Not necessarily. And in view of the fact that your mother gets along well without you, it would appear that your feelings of self-condemnation were wasted. Why be ashamed of leaving your mother when such action does her no harm and does you a great deal of good?

PATIENT: I can't pick any quarrel with that. I guess I just haven't gone far enough with my own reasoning. You bragged about me too soon.

DOCTOR: Don't let that discourage you. It is awfully hard to know one's self.

PATIENT: Well, I can see that it is foolish for me to condemn myself for leaving Mother occasionally, and I believe I shall be able to discard that feeling—but I'm home now. I'll probably not be going away again for a long time, and that understanding of myself won't be particularly useful.

DOCTOR: Can't you use it when you go out here in town with your friends?

PATIENT: I'm afraid I won't have much chance. I'll want to be with Mother as much as possible.

DOCTOR *(looking at patient intently)*: Do you really enjoy caring for her?

PATIENT *(after long pause)*: That's a hard one for me to answer, Doctor. You remember you also asked me to try to analyze how I felt about coming back to her after my first trip to Kansas City. Would my feelings at that time indicate whether or not I am pleased with my life at home?

DOCTOR: I'm inclined to think they might. It is reasonable to assume that a mass of diffused feelings would be brought to a focus at a time like that. You had been away for two months. You had had a good time. Then you were suddenly confronted with the same old life. You became quite ill.

PATIENT: I know that, and I know this distressing insomnia began at that time. And I feel now that it wasn't pure coincidence—knowing what I do about the effect of emotions. But I still can't tell you exactly how I felt and why. *(Pause.)* I guess I felt discouraged. *(Pause.)* I'm afraid that's the best word I can muster. But it's inadequate. *(Then brightly)* I expect I felt like an old-maid school-teacher on Labor Day. *(Smiles.)*

DOCTOR: Then I guess you don't like your job.

PATIENT *(reluctantly)*: I suppose it amounts to that. I certainly enjoyed myself more when away. Yet it isn't true that I actively and constantly dislike caring for Mother. She is very sweet and appreciative. I like to be of service.

DOCTOR: Of course you do. But when it conflicts with your natural desire for romance and gay companionship, you doubtless resent your mother's invalidism and the ties it imposes on you.

PATIENT: I've felt bitter at times when I have had to miss a particularly nice party—but I've tried to keep it to myself.

DOCTOR: I've no doubt you succeeded. But do you think that is good for you?

PATIENT: From what I have learned—no. I suppose it sets up a conflict within me that disturbs a lot of functions. *(Pause.)* But what can I do about it? I've got to live at home and *(defiantly)* if you are asking me to be mean and nasty to my mother in order to get that bitterness out of my system, I rebel. I won't do it!

DOCTOR: An explosion or two probably wouldn't hurt either of you, but since we are supposed to be civilized, we must forego such healthful outbursts. In lieu of that outlet for our pent-up steam, we try to rationalize. You feel bitter when you miss a nice party and, being civilized, you hide that resentment, you turn the venom inward, but it won't stay put. In your case it has come to the surface as an anxiety state, a generalized tension, with inability to sleep and so forth. But is it necessary either to explode or to turn the poison inward?

PATIENT: What is the other alternative?

DOCTOR: Why can't we compromise?

PATIENT: Shall I, then, explode a little one day and brood a while the next?

DOCTOR: You are too literal—too embarrassingly accurate. I mean that we might compromise with the situation, so that neither course would be necessary. Go to more parties and at the same time look upon your work of caring for your mother as a mere incident in your life—a job that you perform in a cheerful, tactful manner, but a job that has limitations, so that you may lead a life of your own outside the job.

PATIENT: But, Doctor, that seems selfish to me. If I went out a lot and had a good time at Mother's expense, I would probably brood about that, and it would very likely start another one of these darned conflicts.

DOCTOR: Would it be at her expense? Might she not be better if she developed a little self-reliance, a bit of self-sufficiency?

PATIENT: Those qualities are probably assets to any one.

DOCTOR: Particularly to invalids. They can't be very happy or contented without them.

PATIENT: Then it wouldn't be selfish to go out at night and leave her?

DOCTOR: Quite the contrary—if you can take the sensible, long-range viewpoint.

PATIENT *(smiling)*: Could I be convicted of practicing without a license if I try to train her to struggle along without me?

DOCTOR *(smiling)*: I'll never report you. I think it's a splendid idea. I'm sure you can do it tactfully. It will be a great benefit to both of you.

PATIENT: I'll start to-night. I turned down a date, but I think I can get it back.

DOCTOR: Splendid! Do you mind if I write a letter to your father explaining the situation? If he knows more about it, he'll be better able to help us.

PATIENT: I wish you would. Dad is a good egg, but just a "little" narrow for us, I'm afraid. He still thinks a daughter's place is in the home. You might suggest to him that he, Sis, and I work there on an eight-hour-shift basis. *(Pause)* No—I'm getting smart-Alecky. However, we'll work it out some way.

DOCTOR: I'm sure you will. I don't believe you'll need me any more.

PATIENT *(sincerely)*: You've helped me a lot. I hope I can hang on to the long-range view of myself and Mother. If the vision gets blurred and messed up, may I come back?

DOCTOR: Of course. But unless you have too much trouble, don't come for a month. Then we'll check you up and mark off the progress.

(Both rise.)

PATIENT: I'll be here. *(Grins impishly.)* That is, if I don't oversleep.

DOCTOR *(chuckling)*: You're cured.

PATIENT *(moving toward exit)*: Good-by, Doctor—and thanks.

DOCTOR: Good-by.

(Exit patient.)

THE PSYCHOLOGICAL HYGIENE OF INFANT FEEDING

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THE supervision of infant feeding represents in many ways the most fundamental achievement of modern preventive medicine. Many nurses and physicians conceive this important work only in terms of bodily nutrition. But from a monistic medical standpoint, it is impossible to advance the hygiene of infant feeding solely on a physical basis. There are psychological factors. They are so ubiquitous that they demand attention.

The infant must be weighed on avoirdupois scales. We must know whether he is gaining. But we must also know how he is functioning as an individual, how he is growing psychologically. His body consists of more than tangible tissue. It comprises those invisible chemical systems and patterned structures which are expressed in physiological processes and in behavior forms. Under thoroughgoing biochemical concepts, "the mind," "the personality," "the reactions" of the infant are brought into identification with his nutrition and his feeding characteristics. Indeed, the most distinctive aspect of his bodily make-up expresses itself subtly in his patterns of behavior.

These patterns of behavior constitute the psychological factor. They are the outward indicators of mental status and of mental growth. They yield to scientific study by objective methods; they are of significance for clinical pediatrics and the mental hygiene of infant feeding.

Ten years ago the Yale Clinic of Child Development began a detailed normative survey of the patterning of infant behavior. This survey embraced carefully selected infants who were examined repeatedly at lunar-month intervals, ranging from the age of four weeks through fifty-six weeks. The purpose of the survey was to determine under controlled conditions the behavior characteristics typical of normal infants from middle-status homes. The behavior was recorded by

means of stenographic reports and by cinema records. When finally analyzed, the data yielded over a thousand behavior items covering several fields of behavior—namely, postural behavior; locomotion; perceptual behavior; prehension; adaptive, language, and social behavior.

A supplementary naturalistic survey dealt with the domestic life of similar normal infants. The purpose of this survey was to chart the natural behavior of the infant in the situations of everyday life. A homelike nursery unit was set up for the purpose of securing systematic cinema records at lunar-month intervals. One-way-vision arrangements made it possible to preserve natural conditions. The nursery was equipped in such a way that the routine of the infant's daily life could be carried through for observation and recording at lunar-month intervals. The mother took entire care of the infant. Feeding, bath, play, sleep, and social situations were charted by the camera and were brought under comparative observation from one month to another. The extensive photographic data of the naturalistic and of the normative surveys are codified in the pictorial *Atlas of Infant Behavior*.[1]

The naturalistic survey was planned to cover the main behavior aspects of the feeding situations, both in terms of the infant's abilities and of the mother-infant relationship. These situations include breast- and bottle-feeding, spoon and cup manipulation, independent and assisted feeding. On regular occasions, with the aid of a pediatric nurse, the accustomed feeding situation was slightly modified to give the infant opportunity to display his capacities for self-help and self-selection. The camera recorded anticipatory reactions; satiety responses; patterns of drinking, sucking, and mastication; reactions to solids; and so on.

Although the records were made under highly favorable conditions, it was felt that a more complete perspective of the development of feeding behavior could be secured only by means of home visits and under consecutive medical supervision. In 1933, Dr. Frances L. Ilg was appointed conference

[1] *An Atlas of Infant Behavior: A Systematic Delineation of the Forms and Early Growth of Human Behavior Patterns*, by Arnold Gesell, M.D., *et al.* (New Haven: Yale University Press, 1934.) See also *Infant Behavior: Its Genesis and Growth*, by Arnold Gesell, M.D., and Helen Thompson, assisted by C. S. Amatruda, M.D. New York: McGraw-Hill Book Company, 1934.

physician at a local well-baby conference and made arrangements to visit the homes of selected infants enrolled at this conference. These visits were begun as soon as the infant was brought home from the hospital, at the age of two or three weeks. Each week, by prearrangement, the home was visited prior to the accustomed feeding time. The whole process of feeding in its everyday context was carefully observed under ordinary home conditions. Nine infants were studied by means of periodic visits up to the age of two or three years.

In the mutual interest of research and of guidance, it was decided to make the supervision of these infants liberal and not too prescriptive. The mother was encouraged to watch the spontaneous demands of the infant. She was not held strictly to a fixed schedule. On the contrary, at each behavior-day inventory, she was encouraged to report her difficulties with and her departures from the standard routine.

This liberal procedure broke down dogmatism and brought about active coöperation on the part of the mothers. It opened the way for safe experimental observation of the baby's spontaneous feeding demands and his natural reactions. It made it more possible for the baby to make a contribution to our study of feeding behavior. Supplementary to the biographic studies, 80 additional infants were followed at weekly and bi-weekly intervals in connection with a well-baby conference.

These periodic studies of the behavior aspects of infant feeding prove that psychological factors are more numerous and complicated than one might suppose. The behavior capacities of the infant undergo continuous changes from week to week and from month to month. Even the presumably reflex act of sucking changes with the maturity of the infant. The tongue, the muscles of the mouth and cheek, and their neurological innervation undergo differentiations which reflect themselves in changing patterns of performance and efficiency. The motor mechanisms of sucking, mastication, swallowing, of the hand-to-mouth coördinations, the manipulation of the cup, the reactions to administered spoon-feeding and to self-initiated feeding, postural adjustments, the weaning transition, bladder and bowel control—all of these phenomena were studied from the standpoint of neuromotor

development. From these data we derive the general conclusion that the maturity of the infant's behavior equipment constitutes a most important psychological factor in the hygiene of his nutrition.

It was possible to investigate the developmental morphology of the feeding-behavior patterns with the powerful aid of cinematography. Extensive cinema records of feeding behavior were subjected to critical analysis with the aid of an analytic projection desk and other devices. On the basis of this cinemanalysis, a systematic sequence of action photographs was assembled to delineate the course of feeding-behavior development from birth to three years of age.[1]

All normal infants in their behavior development tend to follow an ontogenetic sequence which is characteristic of the species. The supervision of infant feeding must take primary account of the maturity differences represented by this ontogenetic sequence. Equally important is a recognition of the individual differences. If we give the infant some opportunity to express his organic needs for food and sleep by his own self-demands, we shall find that the cycle of the behavior day assumes distinctive patterns in different infants. In our own investigation of feeding behavior, we relaxed the ordinary rigidity of supervision in order to bring to light the individual differences and fluctuations in the self-regulation of the infant. Our data suggest that it is wise to give the infant a lead in initiating variations from day to day, because through these variations he tests and achieves his powers.

We assist him by setting up a provisional schedule. But we cannot arrive at the optimum schedule without granting him some latitude for individual fluctuations. An intelligent mother knows how to read and to meet these daily fluctuations. And the physician may well encourage and guide her in this adaptation to his needs.

If the infant's self-demands are ignored in the interests of an inflexible schedule, there ensues a contest between infant and adult. This contest is waged with unnecessary losses and emotional disturbances on both sides. Superficially, it

[1] See *Feeding Behavior of Infants: A Pediatric Approach to the Mental Hygiene of Early Life*, by Arnold Gesell, M.D., and Frances L. Ilg, M.D. Philadelphia: J. B. Lippincott Company, 1937.

might appear that the self-demand schedule would encourage whims and instability in the child. Exactly the opposite is true. For, through individualization of feeding, the infant is most directly and most completely satisfied. He escapes the pangs of frustration and the feelings of anxiety that might follow from undue denials and delays.

Because the deepest and the most vital cravings of the infant have to do with food and sleep, his daily schedules of feeding and sleeping assume great psychological significance. We are too accustomed to think of these schedules from the narrow standpoint of physical regimen and to underrate their effects on mental welfare. Food and sleep should be carefully adapted to the infant's individuality because his growing organism is seeking an optimum realization. Only by individualizing the schedules can we meet his organic needs promptly and fully. By meeting them with certainty, we multiply those experiences of satisfied expectation which create an increasing sense of security. This "sense" is a patterned product of mental growth. It is not a vague essence, but a structured orientation of the infant's total action system. It doubtless has a neurochemical basis just as real as the physical basis of more objective patterns of behavior.

The individualization of food-sleep schedules in infancy, therefore, is essential to mental health. Pediatrics is destined to assume increasing importance in the achievement of a soundly organized mental hygiene of early life.

MENTAL HYGIENE IN AMERICAN COLLEGES AND UNIVERSITIES *

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AMONG colleges and universities, as in other fields of human relations, the matter of mental hygiene has become increasingly a subject of thought and interest. But just how far developments along this line have gone in the college field as a whole has not been definitely known. Accordingly, in connection with the recent national conference on college hygiene,[1] it was felt that it would be both appropriate and useful if specific information could be made available, not only as to recognition of the need for college mental hygiene and the general attitude toward it, but more especially as to present facilities for actual remedial or clinical service.

For this purpose, all things considered, the questionnaire type of approach seemed, despite its limitations, the most satisfactory. Such a questionnaire, therefore, was prepared, being made as simple and brief as appeared consistent with adequacy. This, reply postpaid and with an explanatory covering letter, was mailed at the beginning of the past academic year to 865 American collegiate institutions, the mailing list of the conference. The returns have been distinctly illuminating.

* Grateful acknowledgment is made herewith to The National Committee for Mental Hygiene and to the Earhart Foundation, for financial aid which made this study possible.

[1] The Second National Conference on College Hygiene, held in Washington, D. C., December 28–31, 1936.

The questionnaire was as follows:

QUESTIONNAIRE

RELATIVE TO

COLLEGE MENTAL HYGIENE DATA

1. Do you feel need for attention along mental-hygiene lines to be an important one for college students? Yes. No. (Underline answer desired.)

2. Is a course (or courses) in mental hygiene included in the curriculum of your institution? Yes. No. (Underline answer desired.)

3. Is your institution interested in the establishing of a mental-hygiene consultation service for its students, through which attention or advice would be available on an individual basis? Yes. No. (Underline answer desired.)

4. Has your institution such a consultation service, or unit, at the present time? Yes. No. (Underline answer desired.)

5. If it has such a service, what is its set-up?

a. Directed by—psychiatrist; clinical psychologist; psychiatric social worker; trained personnel worker; interested faculty member (indicate department); general physician affiliated with college? (Underline, or describe if not listed in the foregoing.)

b. Number constituting staff, not including secretarial assistants? .....

c. Make-up of staff? (As, one psychiatrist and one psychologist.)

d. Staff on full-time, part-time, or purely consultant basis? (Indicate for each member of staff.)

e. Total number of students seen in 1935–36, not including summer session or quarter? .....

f. Total number of interviews or contacts required for above, if record kept?

(1) Number student interviews .....

(2) Number interviews about students with other persons concerned .....

g. Status in institution? (As, connected with student health service; dean of students' office; personnel division; other or special administrative connection; independent, responsible directly to head of institution.) (Underline, or describe if not listed in the foregoing.)

h. How long has this service been in operation? .....

i. Does student pay separately for above service? Yes. No. Is such service included in general health service fee or tuition? Yes. No. (Underline answers desired.)

6. If your institution is interested in the establishment of a mental-hygiene consultation service, and has not one, what consideration or considerations stand in the way?

7. Total enrollment of institution, 1935–36, not including summer session or quarter? .....

8. Questionnaire filled out by whom, indicating position or title?

9. Additional remarks or comments. (Use reverse, if necessary.)

The institutions to which questionnaires were sent comprised primarily the four-year, degree-granting group in the United States and its territories,[1] but included also certain United States Negro colleges and a number of Canadian schools. Geographically, they were distributed as follows:

	Number of institutions
United States	810
Territorial	8
Negro	25
Canadian	22
	865

The distribution of the 835 institutions in the United States is indicated below, the concentration being chiefly in the eastern and north-central areas, as might be expected:

	Number of institutions
New England	68
Middle Atlantic	130
East North Central	159
West North Central	120
South Atlantic	131
East South Central	70
West South Central	71
Mountain	32
Pacific	54
	835

Five hundred and seventy-four of these institutions[2] were coeducational (and coördinate), 162 were for women only, and 99 for men. There were 162 teachers colleges. Two hundred and sixty-four institutions were listed as publicly and 160 as privately supported, and 411 were denominational.

Replies were received from 479, or 53.3 per cent, of the institutions circularized.[3] This, though not a strikingly large return, does nevertheless represent a considerable number of schools and would seem to be at least a significant index of

[1] *Educational Directory, 1936.* Washington: United States Department of the Interior, 1936. Part III.

[2] Territorial and Canadian schools were omitted from the categories considered in this paragraph and wherever these categories may be mentioned subsequently, because information on these points was not readily available for these two groups; also because of their small numbers.

[3] In the case of two institutions, offers to supply information after tabulation had been completed were not followed up.

interest and of the general situation prevailing. As to the institutions that failed to reply, it seems decidedly a pertinent question whether, in the main, there was not in their case a lack either of any special interest in the subject or of noteworthy developments in response to such interest.

Of the institutions in each of the various geographical areas, the percentage that replied was as follows:

	Percentage of institutions replying
New England	52.9
Middle Atlantic	53.0
East North Central	61.0
West North Central	60.8
South Atlantic	46.5
East South Central	45.7
West South Central	59.1
Mountain	43.7
Pacific	64.8
Territorial	37.5
Canadian	77.4

From this, it would seem that of the areas that have the largest numbers of schools, the North Central section gave the greatest response, while among other areas the West South Central, the Pacific, and the Canadian groups were outstanding.

The return from the public schools was 68.9 per cent, from the private 60.9 per cent, and from the denominational 43.7 per cent. Also of interest was the large number of answers from the teachers colleges—67.9 per cent. Replies from the coeducational institutions totaled 59.0 per cent, from the men's schools 52.5 per cent, and from the women's colleges only 38.6 per cent. In the case of the 25 Negro colleges, there were responses from 11, or 44.4 per cent. Further, of the total number of replies, 40.0 per cent were from small schools, 43.1 per cent from schools of medium size, and 16.7 per cent from large institutions.[1]

[1] Institutions with 500 students or less were arbitrarily classified as small; with from 500 to 2,000, as medium; and with over 2,000, as large. In 25 instances, information as to enrollment was obtained from available catalogues, the schools themselves not having included data on this point on the questionnaries returned. Also territorial and Canadian schools were not analyzed from this standpoint, which should be borne in mind wherever size is discussed subsequently in this paper.

To the first question—"Do you feel need for attention along mental-hygiene lines to be an important one for college students?"—93.5 per cent of the replies were in the affirmative, and 2.9 per cent in the negative; in 3.6 per cent this particular question was not answered.

The distribution of affirmative replies geographically and by type of institution was as follows:

Location	*Percentage of replies in affirmative*
New England	97.2
Middle Atlantic	91.3
East North Central	90.7
West North Central	95.8
South Atlantic	96.7
East South Central	96.8
West South Central	90.4
Mountain	100.0
Pacific	97.1
Territorial	100.0
Canadian	76.4
Type of institution	
Public	95.6
Private	95.8
Denominational	91.6
Small	92.2
Medium	96.3
Large	92.2
Coeducational	95.6
Men's	84.6
Women's	93.6
Teachers colleges	95.4
Negro colleges	100.0

From the foregoing, it appears plain that an appreciation, at least, of the importance of mental hygiene as an aspect of student welfare is quite general. So far as the special groups are concerned, nothing stands out particularly, save, perhaps, the relatively lower return from the men's schools.

To the second question, as to provision for courses in mental hygiene, 2.6 per cent of the institutions gave no answer; 38.6 per cent answered in the affirmative and 44.3 per cent in the negative, while 14.4 per cent stated that mental hygiene was in some measure included or treated in other courses, such as "Abnormal Psychology," "Principles of Constructive Hy-

giene," "Human Biology," "Personal and Community Health," and courses in religion.

The following responses were noted for the various special groups:

Location	*Percentage providing courses in mental hygiene as such*	*Percentage providing courses with some mental-hygiene content*
New England	30.5	19.4
Middle Atlantic	42.0	13.0
East North Central	41.2	17.5
West North Central	35.3	13.7
South Atlantic	31.1	13.1
East South Central	34.3	12.5
West South Central	40.4	16.6
Mountain	57.1	7.1
Pacific	51.4	11.4
Territorial	33.3	66.6
Canadian	29.4	....
Type of institution		
Public	48.3	15.0
Private	39.1	11.3
Denominational	30.0	16.1
Small	30.9	16.2
Medium	41.4	13.6
Large	51.9	12.9
Coeducational	41.2	13.3
Men's	28.8	11.5
Women's	34.9	23.8
Teachers colleges	49.1	16.3
Negro colleges	9.1	9.1

From these data it is quite apparent that there has been a perceptible development of specific courses dealing with the subject matter of mental hygiene, although admittedly this development is far from complete. However, if one considers, in addition, courses that have mental-hygiene inclusions and implications, the percentage is encouragingly higher—53.0. For the special groups, the large number of teachers colleges that reported courses is worthy of mention; also the fact that provision for courses seems to vary in direct relation to institutional size. Further, less provision of mental-hygiene courses was reported for men's and women's colleges than for coeducational schools. In the women's colleges, however, a

considerable number of other courses with some mental-hygiene content seem to be available. We note also that a larger percentage of the public schools reported provision for courses than of the private and denominational institutions, and that, geographically, the highest percentage of positive replies was received from the West.

To Question 3—with regard to interest in the establishment of actual consultation or clinical services—positive replies were made by 215, or 79.9 per cent,[1] of the institutions that answered in which services did not already exist. This response is really a striking one.

The percentages for the various special groups were as follows:

Location	*Percentage indicating interest in service*
New England	80.0
Middle Atlantic	63.4
East North Central	81.7
West North Central	89.5
South Atlantic	78.0
East South Central	82.5
West South Central	84.4
Mountain	75.0
Pacific	85.7
Territorial	100.0
Canadian	50.0
Type of institution	
Public	84.4
Private	73.0
Denominational	76.7
Small	76.6
Medium	84.8
Large	82.0
Coeducational	87.0
Men's	50.0
Women's	57.6
Teachers colleges	91.5
Negro colleges	100.0

[1] That is, 44.8 per cent of the 479 institutions that returned questionnaires. Fifty-four, or 11.2 per cent, replied in the negative, and 12—2.5 per cent—did not answer this question. One hundred and ninety-eight—41.3 per cent—had services already established.

Noteworthy here is the high percentage of positive replies from the West North Central area. Also deserving of mention is the very high percentage of replies indicating interest from the Negro and teachers colleges, and from the coeducational schools as compared with the women's and men's schools. Interest, too, seems somewhat greater in the public than in the private and denominational schools.

The reasons given, by institutions interested in remedial services, for not having as yet set up such services, deserve some comment.[1] By far the most common, appearing 168 times, was financial inability. Fifteen institutions mentioned an already heavy activity load, and 13 lack of adequate personnel. Five stressed the matter of an unfavorable location from the point of view of available facilities. Other reasons were "lack of sufficient interest" by the institution as a whole, "need not acute," "never been suggested," "importance questioned," "inertia," "long experience with students" sufficient. Seven felt the need of further and more definite information as to the nature and functional operation of mental-hygiene or psychotherapeutic services, and of assurance as to their positive value.

In answer to Question 4, 198, or 41.3 per cent, of the 479 institutions that returned questionnaires stated that they had consultation services in some form. The situation for the special groups is indicated below:

Location	*Percentage reporting services*
New England	58.5
Middle Atlantic	49.0
East North Central	48.5
West North Central	34.0
South Atlantic	32.7
East South Central	28.1
West South Central	23.8
Mountain	42.8
Pacific	51.4
Territorial	66.6
Canadian	35.3
Type of institution	
Public	39.0
Private	59.7
Denominational	33.8

[1] Response was made by 186 institutions, which gave in all 239 reasons. Twenty-nine institutions of the 215 in this category gave no reason.

Small	32.6
Medium	41.9
Large	61.0
Coeducational	38.9
Men's	51.9
Women's	46.0
Teachers colleges	35.4
Negro colleges	9.0

Geographically, services seem more frequent in the New England, Middle Atlantic, East North Central, and Pacific sections, and less so in the South. The teachers and Negro colleges appear rather poorly provided for, despite interest and realization of need. In general, as might be anticipated, perhaps, provision of services varied in direct proportion to size of enrollment. More provision was reported for men's and women's colleges than for coeducational schools, and more for the private than for the public and denominational schools.

From the data at hand, the various services disposed themselves quite naturally into two main groups, one marked by definite and well-crystallized organization—that is, official units operating in a systematic and continuous way—and the other rather loosely organized, irregular in operation, often coming into play only as special cases presented themselves and functioning frequently rather along the lines of general guidance, welfare, and health than as specifically psychotherapeutic services. In many instances, too, these latter were dependent upon some particular interested person or persons in the faculty whose major work was of another sort, and whose attention was available only upon a part- or spare-time basis.

The first group, comprising 142 [1] schools, we have termed, for purposes of classification, the formal type, and the second, including 46 schools, the informal type. The formal group was further differentiated into those in which the units were definitely under psychiatric direction and those in which other modes of direction obtained. There were 43 of the first and 99 of the second. In addition, two formal services organized along both psychiatric and psychologic lines were

[1] For this analysis, it was thought more pertinent to include only institutions in the United States proper. The territorial and Canadian schools are considered separately in a subsequent section.

classified as "special," since the actual type of direction employed was not clear from the data supplied.

The numerical distribution of the various types of service among the special groups was as follows:

Location	*Formal psychiatric service (Type A)*	*Formal non-psychiatric service (Type B)*	*Informal service (Type C)*	*Special service (Type D)*
New England	9	12	..	..
Middle Atlantic	12	16	5	1
East North Central	6	24	16	1
West North Central	3	13	9	..
South Atlantic	5	9	6	..
East South Central	2	6	1	..
West South Central	..	7	3	..
Mountain	2	3	1	..
Pacific	4	9	5	..
Type of institution				
Small	3	32	25	..
Medium	17	48	18	..
Large	23	19	3	2
Coeducational	28	69	35	2
Men's	8	16	3	..
Women's	7	14	8	..
State	14	40	16	1
Private	23	27	7	1
Denominational	6	32	23	..
Teachers colleges	4	21	14	..
Negro colleges	1	..	..	..

The formal psychiatric services (Type A) are further analyzable as follows:

	Number of institutions
Full-time psychiatrist (or psychiatrists)	3
Full-time psychiatrists associated with or assisted by non-medical worker (or workers)*	4
Part-time psychiatrist	13
Part-time psychiatrist associated with or assisted by non-medical worker (or workers)	4
Psychiatrist on purely consultational basis	5
Psychiatrist on purely consultational basis, associated with or assisted by non-medical worker (or workers)	1
Psychiatrist on purely consultation basis, with use of outside clinics	5
Services of medical schools utilized	8

* Such as psychiatric social workers, personnel workers, or psychologists.

From this, it appears that what might be regarded as the ideal type of set-up—*i.e.*, full- or part-time psychiatric direction, supplemented by the services of trained lay or non-medical workers—has been as yet but little developed. Actually only 10 of the units, including those designated as "special," seem to be of this type. The greater number appear to be serviced entirely by part-time or consultant psychiatrists, with a number of institutions making use of extramural clinics or the facilities of associated medical schools.

As to the institutional status or connection of the service, of the 29 schools that answered this question 26 indicated one connection and 3 two points of articulation with the school structure. In 22 instances, the unit was connected with the health service, in 7 with the dean's office, and in one case each with the department of psychology and the personnel department. One unit was independent, responsible directly to the president.

The period during which the various units had been in existence ranged from less than a year to 15 years, the average being 5.8 years.

Regarding payment for the services offered, among the 37 institutions that replied on this point, special charges were made in 7, with no charge in the remainder beyond regular tuition or health-service fees. As to the percentage of student enrollment seen by the service, this ranged from 35 per cent to less than 1 per cent in the 22 institutions that gave information on this point. In 72 per cent of these schools, less than 8 per cent of the student body was seen, the average being 7.1 per cent.

The formal non-psychiatrically directed services (Type B) included the following varieties of set-up:

	Number of institutions
General physician (or physicians)	5
General physician associated with or assisted by non-medical worker (or workers)	10
General physician with some psychiatric experience	2
General physician with some psychiatric experience, associated with or assisted by non-medical worker (or workers)	2
General physician, with provision for consultation with psychiatrist in special cases	1

	Number of institutions
General physician, associated with or assisted by non-medical worker (or workers), with provision for consultation with psychiatrist in special cases	5
General physician with some psychiatric experience, with provision for consultation with psychiatrist in special cases	2
General physician with some psychiatric experience associated with or assisted by non-medical worker (or workers), with provision for consultation with psychiatrist in special cases	2
Psychologist (or psychologists)	26
Psychologist, with services available from general physician without special experience in psychiatry	12
Psychologist, with provision for consultation with psychiatrist in special cases	1
Psychologist, with services available from general physician without special experience in psychiatry, and with provision for consultation with psychiatrist in special cases	6
Religious adviser (or advisers)	3
Religious adviser, with services available from general physician without special experience in psychiatry	2
Personnel worker (or workers)	6
Personnel worker with services available from general physician without special experience in psychiatry	6
Personnel worker, with provision for consultation with psychiatrist in special cases	4
Personnel worker, with services available from general physician without special psychiatric experience and provision for consultation with psychiatrist in special cases	3
Nurse with psychiatric experience associated with professor of hygiene	1

It is interesting to note from the above that the services of physicians with special psychiatric experience or background were available in only 28 of these 99 institutions.

Of the staffs, 27 of the 99 were apparently on full time and 37 on part time; in 20 institutions, the services were purely consultational; and in 15 instances no information on this point was available. As to the time during which the service had been in operation, the range was from less than one year to 26 years, with an average of 6 years.

Of the 94 institutions that replied on this point, a special fee for service was reported by two.

Of the 79 that gave information on institutional status, 60

cited one connection, 16 two connections, and 3 three connections. Specifically, these connection points were as follows:

	Number of institutions
Health service	41
Personnel department	24
Dean's office	18
Independent, responsible directly to head of institution	8
Psychology department	6
Education department	1
Student-counseling department	1
Bureau of vocational guidance and mental hygiene	1
Director of guidance	1

As to the 46 informal services (Type C), in the main, as indicated, these were rather loose in organization and usually were carried on by a number of persons or agencies. Thus, from the information available for this group, the service was rendered by one person or agency in 8 cases, by two in 16, by three in 11, by four in 7, and in two cases each by 5 and 6 participants. The various persons or departments concerned were as follows:

	Number of institutions
Psychologist or member of psychology department	28
Dean's office	20
Institutional physician	17
Personnel worker	7
Psychiatrist available to whom special cases may be sent	6
Religious adviser	5
Institutional nurse	4
Department of physical education	3
Head of institution	3
Education department	3
Sociology department	3
Psychiatric social worker	1
Director of social office	1
Department of coöperative work	1
Health department	1
Professor of biology	1
Registrar	1
Professor of philosophy	1
Faculty members (departments unspecified)	17

Also, in 18 schools the service appeared, from the data available, to be included in the functions of personnel depart-

ments or units of varying constituency, facilities, and adequacy.

As to actually stated official connection (Question 5g), one connection was given in 23 instances, two in 3, and three and five connections in one case each. In 18 cases, it may be added, no information was given. These official centralization points were as follows:

	Number of institutions
Dean of students	10
Independent, responsible directly to head of institution	8
Health service	6
Psychology department	6
Personnel department	4
Health and Physical Education Department	1
Physical director	1
Director of social office	1

Duration of operation ranged from less than one year to 15, with an average of 4.2 years. A special charge, over and above the regular tuition or health-service fees, was noted in the case of only two of the 36 institutions that gave information on this point.

Replies relative to the number of interviews with and concerning student clients were too few and indefinite, for all types of services, to make possible meaningful tabulation or comment. Accordingly, they were not included in this report. For the same reason, comment respecting the number of students seen by the service has been omitted in the case of schools with services of types B and C.

The territorial schools reported two services, both of the formal, psychiatrically directed type. Of the Canadian institutions, six reported services, two of the informal type and four of the formal, three of the latter being psychiatrically directed.

From the data secured through this inquiry, it seems evident that a decided awareness of the importance of mental hygiene for student welfare obtains among American colleges and universities. Further, this awareness appears in significant degree to have advanced beyond the point of mere realization, and already to have begun to crystallize in terms of

practical use and procedure. Thus, in many schools, courses that give mental-hygiene information are offered. While, admittedly, the number of such school falls considerably short of the total, and while, even in such courses as are available, there is undoubtedly much room for development and improvement, what has been accomplished is enough to indicate an unmistakable trend. Also, in not a few institutions, actual remedial or clinical services have been established. While the number of these is by no means great, especially in the form deemed best for greatest effectiveness, nevertheless it is sufficient to demonstrate definite progress in response to recognized needs. This is especially significant and encouraging in view of the recent period of greatly reduced financial resources. Moreover, these services do not represent a strikingly new or sudden phenomenon, but rather a steady growth, the present development seeming to have taken on a special impetus some five years ago. Particularly gratifying and significant, incidentally, is the interest shown by teachers colleges, in view of the very special responsibility and opportunity implicit in the teacher-pupil relationship.

Of course, much remains to be done, but in view of the still formative state of this aspect of mental hygiene or psychiatry, and of the psychotherapeutic approach generally, the present situation seems decidedly encouraging. As mental-hygiene work develops and proves its value, and as colleges, with the interest that seems to exist, keep in touch with its possibilities, much may be expected. At present the work is carried on by a great variety of persons of differing technical backgrounds and effectiveness, in a wide variety of ways, and under a variety of auspices, largely without any definitely and generally accepted standards or formulæ. This, of course, is understandable, since the application of mental hygiene, as a specific technical and professional approach, to the college situation has been comparatively recent and, of necessity, to a large degree tentative and experimental. Cumulative experience, however, has definitely begun to show precipitation in terms of pragmatically worked out indications for set-ups and procedure as, for example, in connection with the recent

national conference on college hygiene.[1] As further development takes place, it should be possible, through liason between educators and clinical workers, to devise adequate services adapted to the different types of institution and integrating, in a practical and organized manner, the various aspects essential to really authentic and effective counseling programs, including in its proper place that of mental hygiene or psychiatry.

Finally, that such a development will take place seems virtually inevitable, if for no other reason than the constantly increasing demands and pressures evident on all sides, emanating largely from the life and consciousness of the community itself. And, for a constructive outcome, the major responsibility, naturally, rests upon those professionally most directly concerned—the teacher, the personnel worker, and the mental-hygienist, operating together.

[1] See *Proceedings of the Second National Conference on College Hygiene* (New York: National Tuberculosis Association, 1937). For a somewhat expanded and elaborated report of the conference's Subcommittee on Mental Hygiene, see *Mental-Hygiene Services for Colleges and Universities*, by Theophile Raphael, M.D. MENTAL HYGIENE, Vol. 21, pp. 559–68, October, 1937.

A FRENCH FAMILY-CARE COLONY *

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THE outstanding achievements of the colony for the family care of mental patients at Gheel, Belgium, have given rise to many experiments along similar lines in other countries. Among the most interesting and most successful of such experiments is the one made in France which forms the subject of this communication.

On the 17th of December, 1892, Dr. August Marie opened the first family-care colony in France at Dun-sur-Auron in the Department of Cher. The establishment of this colony by the Council General of the Seine was the outcome of a long series of discussions which followed investigations of family care in Gheel and Scotland. Dr. Marie, who had made a special study of the Belgian and Scottish systems and had become an enthusiastic advocate of family care, took a leading part in these discussions. His convincing arguments secured the desired action. As the mental hospitals of the Seine at the time were overcrowded, the Council General was faced with the necessity of providing additional accommodations either in a new hospital or in a family-care colony.

After careful investigation, the city of Dun was chosen as the site of the new colony. This ancient Celtic town, which was in existence when Caesar conquered Gaul, has had a remarkably interesting history. Its present walls, ramparts, and towers bear silent testimony to its age and to its long struggle for survival. Its population, which was about 4,000 in 1892, has changed but little since that time. The city is situated in the north central part of France about fifteen miles from Bourges and about one hundred and sixty miles from Paris. The inhabitants of Dun are artisans, shopkeepers, boatmen, gardeners, and farmers. Many of them own their own homes. These are mostly modest houses with small gar-

* The author wishes to acknowledge with gratitude his indebtedness to Dr. J. Vié, who made the arrangements for his visit to Dun, and to Dr. Chanès who entertained him and showed him the various parts of the colony center and the family homes of many patients.

den plots. The iron mines and vineyards, which formerly had provided adequate sources of income for the inhabitants of Dun, had disappeared. The citizens, therefore, welcomed the colony, which offered a new source of revenue. Prior to the opening of the colony a public conference concerning the project was held in the city. The mayor and several leading citizens advocated the establishment of the colony and many of the inhabitants offered to become guardians of patients. Public sentiment strongly favored the project.

It was decided to move slowly in developing the new colony. In December, 1892, only 24 patients were transferred from the mental hospitals of the Seine to the colony. These were soon well placed and others followed. By the end of 1893, 108 patients had been received. Each year thereafter showed an increase until in December, 1903, the number of patients in the colony reached 900. Since that time there has been an irregular upward trend. On December 31, 1935, the number was 1,323. It has since mounted to about 1,500. As the colony became larger it was necessary to make placements in the villages surrounding Dun. On December 31, 1935, there were 679 patients in families in Dun, 89 in the colony center, 550 in families in eight nearby towns, and 5 on leave. The largest number of patients in any of the villages outside of Dun was 122, at Ourouër.

The development of the colony center has kept pace with the increase of patients. At first it consisted of small quarters which housed the administrative personnel, and an infirmary (D) with eight beds. Baths for patients were installed in the municipal washhouse. In 1897, a small pharmacy was installed; in 1898, Infirmary R with 16 beds was built; in 1899, Infirmary D was enlarged to accommodate 12; and in 1900, Pavilion Henri Le Roux was begun. This building, which was opened in 1902, was designed to care for about 70 patients. It was necessary to have such a ward for patients awaiting family placement and for patients returned by families. Other additions to the center installed at various times include an autopsy room, a laundry, a bathhouse, and an assembly hall.

Personnel.—The employed personnel of the colony in the beginning consisted of the medical director, a clerk, and two nurses. These proved sufficient to handle a patient popula-

tion of 213. The medical and nursing personnel at present comprises a medical director, a head physician, three medical assistants, eight visitors, two inspectors, two solicitors, and sixteen nurses, a total of thirty-three. The administrative personnel comprises, in addition to the medical director, nine clerical employees, two laundry employees, two gardeners, a coachman, a cook, a porter, an electrician, and a chauffeur. Thus the entire employed personnel consists of 51 persons, constituting a ratio of about 1 employee to 30 patients. Naturally a large part of the work at the colony center and in the colony gardens is done by patients.

Patients.—The colony at Dun was established primarily for women patients. However, a few men are received from the hospitals of the Seine to help in the heavier work connected with the maintenance of the colony center and the cultivation of the gardens. Actually on December 31, 1935, there were 1,301 women and 22 men patients on the colony rolls. The women patients are mostly over fifty years of age.

The colony receives both psychotic and mentally defective patients and apparently makes no distinction between these classes when placing patients. Of the 152 admissions of 1935, 62 were classed as mentally defective and 90 as psychotic. Nearly all groups of mental disorders were represented.

The patients come to the colony by transfer mainly from the hospitals of the Seine. Usually about 20 patients compose a transfer. Upon their arrival at the colony, the patients are quickly inspected and put under observation in the infirmaries and pavilion. The following day each of the new arrivals is photographed and given a physical and mental examination. As the colony has a long waiting list of families desiring patients, the placement of the new group receives immediate attention. As a rule, admissions remain at the colony center from one to six days. When a patient is deemed ready for placement, an effort is made to give her a suitable home. Factors taken into consideration in selecting a patient for a given home or a home for a given patient include the mental and physical condition of the patient, her temperament, her school training, her economic and social status before the onset of her mental disease, her previous occupation, and her present behavior. The type of home available and the other woman patient who is to live in the same home are also con-

sidered. Care is taken to place patients where they will be happy and will receive the maximum benefit from their new life.

The transition from hospital to family life is made as easy as possible for the patient. The colony nurses have become so skillful that the first placement proves successful in most cases. When necessary, a second or third attempt is made to find a suitable home for the patient. The few patients who fail to adjust to family life after many trials are returned to the mental hospital.

Supervision.—The colony center maintains close supervision over the patients in family care. "Free life with active and continuous medical supervision" is the governing principle in the management of the colony. Patients living in families are as free as members of the family. Houses are usually locked at night, but during the day patients may stroll at will through the streets and parks of the city. They may also go shopping or visiting. They naturally are required to be home at meal time and bed time.

In the city of Dun, 306 families were caring for 679 patients at the end of 1935. The city is divided into 11 sections. A visiting physician with an inspector covers a section a day. Visits are so regulated that each patient is seen by a physician once a week and oftener if necessary. Patients who become seriously ill are brought back to the center for treatment.

The success of the whole undertaking depends in large measure upon the work of the visiting physician. He encourages the patients, arranges suitable work or recreation for them, gives them medical aid when necessary, advises them concerning their daily routine, and keeps close account of their improvement or decline. He also instructs the guardians with reference to the management of the patients. If the food given patients is in any way inadequate, he orders proper changes. Likewise, he requires, when necessary, suitable modifications of home arrangements to promote the patient's comfort. Should the patient require medicine, he writes a prescription which the patient or the guardian has filled at the colony pharmacy. Through frequent visits, the physician becomes well acquainted with both patients and families. They learn to regard him as a wise and friendly counselor

and freely consult him concerning any problem that may be troubling them.

The visits of the physicians are supplemented by visits to each patient at least once a week by an inspector or visiting nurse. These officials give careful attention to all matters pertaining to the well-being and comfort of the patient. They report to the director concerning the health of the patients and any other matters that require his attention.

Health of Patients.—The colony maintains an excellent record in the matter of the physical health of its patients. During the year 1935, 171 patients were treated in the infirmaries for physical diseases that did not require surgical attention; in addition, 56 patients were operated on for minor or major conditions. The deaths of patients during the year numbered 56, the death rate being 38.3 per 1,000 patients treated. Of the 56 deceased patients, 23 were between fifty-five and sixty-nine years of age and 26 were seventy or over. When the age and mental condition of the patients are considered, the death rate is not excessive.

Two patients committed suicide in 1935.

Movement of Patients.—The general movement of patients to and from the colony indicates in some measure the extent and success of colony activities.

GENERAL MOVEMENT OF PATIENTS, DUN-SUR-AURON, 1935

	Men	*Women*	*Total*
In colony, January 1, 1935	22	1,285	1,307
Admitted during year	2	150	152
Total treated during year	24	1,435	1,459
Departures:			
Discharged, recovered, or improved	1	12	13
Returned to mental hospital	..	62	62
Transferred	..	2	2
Died	1	55	56
Escaped	..	3	3
Total departures	2	134	136
In colony December 31, 1935	22	1,301	1,323

As most of the patients received in the colony had previously been under treatment in a mental hospital from one to

fifteen years, few recoveries could be expected. The return to a mental hospital of less than 5 per cent of the patients treated during the year is of itself presumptive evidence of the efficiency of the system and the high quality of family care at the colony.

Distribution of Patients in Families.—The 1,229 patients actually in family care in Dun and neighboring villages on December 31, 1935, were distributed in 529 families. The distribution was as follows:

Patients per family	*Number of families*
1	32
2	300
3	191
4	6
	529

Effort is made to place two or three patients in a family whenever practicable. In some cases a single patient is taken in by a family as one of the family circle, but often the single patient becomes lonesome and discontented. Ordinary dwellings in Dun are small and not suited for more than three patients in addition to the family. Moreover, it is not thought desirable to place more than three patients with a family. With more than this number the family character of the placement is likely to be lost and replaced by an inferior boarding-house environment.

Selection of Guardians.—Guardians are selected by the medical director and his assistants from a register of eligibles established and maintained at the office of the mayor of each city and village included in the Dun colony. In order to qualify for registration, a family must show that it can satisfy the essential conditions for the care of patients. These include good moral character, proper deportment, cleanliness, and ability to provide patients with suitable room, food, heat, light, and sanitary facilities. Before assigning a patient to a family, the home is inspected and its suitability for the care of a particular type of patient is determined. In this way success of placements is made probable.

The guardians are instructed by the colony physicians and are also given a printed list of rules and directions. These rules show clearly what is expected of the guardians in the

management of patients, and give directions in regard to the food and clothing of the patients.

Selection of Patients for Family Care.—In Gheel nearly all classes of mental patients are placed in families. This is made possible by the sympathetic attitude of the inhabitants of the community toward patients and by the skillful management of patients by trained guardians. In such a colony the patients come from the community to the colony center and are promptly placed in families. In Dun, conditions are quite different. Patients come to the colony center, not from the community, but from mental hospitals in which they have been under treatment for several months or years.

The selection of patients for the Dun colony is made by the physicians of the mental hospitals of the Seine. The medical director at Dun receives the patients sent to him and places those found suitable for placement. The few that cannot be placed and those who fail in family care after repeated trials are returned to the mental hospitals.

As previously mentioned, the colony at Dun is primarily for women. The neighboring colony at Ainay-le-Chateau is for men. As Dun maintains free life under medical supervision for all its family-care patients, admissions above the age of fifty are preferred, although 31 of the 150 women admitted in 1935 were under forty-five. Only 30 of the admissions of the year had been in a mental hospital less than one year.

In choosing patients for Dun, more attention is given to the character and conduct of the patient than to mental diagnosis. Is the patient capable of adapting to the free life of the colony? Is she inoffensive in speech and manners? Is she free from physical diseases or defects that would cause her to be shunned by others? Is she tractable and willing to work? If these questions can be answered in the affirmative, the patient would probably be deemed eligible for colony life.

Occupation and Amusement.—Patients in family care in the colony are not required to work, but all who are physically able are encouraged by the physicians, visiting nurses, and guardians to take part in some purposeful activity. The patient who is able and willing to work may within limits choose the work she desires and her place of occupation. In 1935, 93 patients were employed in the colony center making and repairing clothing, mending shoes, doing household and

kitchen work, cultivating the garden, and caring for the buildings and grounds; 152 patients are regularly employed by families or shopkeepers and are paid wages commensurate with their work. About 200 patients work in their rooms making underwear, or knitting. The productive capacity of most of the patients is of course small. They are permitted to spend most of the money earned as they desire. Some of it goes for needed clothing and some for luxuries or amusements.

The assembly hall at the colony center serves as a motion-picture theater and as a meeting place for members of the colony. On each Sunday and holiday entertainments are given in the hall and refreshments are served to the patients in attendance. Patients are at liberty to attend entertainments in the city, to visit the parks, or stroll in the country, or even fish in the river or canal.

Patients who do not have good bathing facilities in their family homes come to the colony bathhouse more or less regularly for their baths.

Cost of Family Care at Dun.—The capital outlay for the colony center at Dun is very small compared with that required for a mental hospital for 1,500 patients—probably not over one-fourth as great.

The cost of maintenance of patients at Dun, including compensation to guardians, supervision, transportation, administration, and care of patients at the colony center, was about forty cents a day in 1935. The average daily cost of maintenance of patients in the mental hospitals of the Seine in the same year was about one dollar. Moreover, the annual per capita investment charge was much greater in the latter institutions. The guardians in Dun receive about thirty cents per day for the care of each patient. That this amount is deemed sufficient is indicated by the fact that the colony has a waiting list of 200 families who are ready to care for patients.

When visiting Dun in July, 1937, I was most favorably impressed by the management of the colony center under the direction of Dr. Pasturel and Dr. Chanès, by the comfort enjoyed by the patients in their family homes, and by the freedom and excellent behavior of the patients. I am convinced that the system of family care in operation in Dun could be advantageously adapted for use in the United States.

AN EXPERIMENT IN TEACHING PHYSICALLY HANDICAPPED CHILDREN AT HOME *

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SINCE November, 1934, an experiment in the provision of an hour of daily instruction at home for physically handicapped children has been carried on in Scranton, Pennsylvania. The work, proposed by the Visiting Nurse Association, was initiated under the Council of Emergency Education, whose chairman is the county superintendent of schools in Lackawanna County. A volunteer group of forty-four people, consisting of a cross section of the educational, social, and economic life of the community, proposed to provide constructive employment for unemployed persons on relief who were competent to teach and at the same time to develop experimental methods of meeting needs for which no other agency was providing. This committee, known as the Council of Emergency Education, early approved the project for the home teaching of physically handicapped persons, a group whose needs the Scranton Public Schools were not able to meet. The salaries of the teachers have been paid, according to a regulated schedule for certified teachers, first by the C.W.A., then by the F.E.R.A., and of late by the W.P.A. In each case, the standard qualifications have been regarded. Thus the governmental agency, represented by the W.P.A. branch-office manager and the supervisor of educational projects, has coöperated closely with the citizens' committee. In addition to salaries, it has provided funds for office supplies, for psychological material, and for a clerical worker. The headquarters originally provided by the Visiting Nurse Association were outgrown as the project expanded. Now an

* The author would like to take this opportunity to express her appreciation of the assistance of Mr. Sidney W. Koran, who served as psychologist on the Home Teachers Project for almost a year and who was of great help in carrying out the idea of conducting it as a research investigation and in preparing this article.

office, furnished by donations, has been secured in a central office building.

Throughout, the project has been sponsored by the Visiting Nurse Association, the local agency deemed best able to plan and guide the work, because of its knowledge of the convalescent or chronically ill children whose education was being completely neglected and who were developing undesirable personality traits which might outlive the original physical handicap. The association has granted time to its mental-hygiene supervisor for supervisory guidance of the project.

Close coöperation between the superintendent of schools, together with the school child-study department, and the sponsoring agent, has kept attention properly balanced between the school work and the physical needs of the child. Visits to handicapped children are in each case sanctioned by the attending physician, who, on a form especially prepared for this purpose, indicates the diagnosis, states the maximum number of hours to be devoted to home instruction, and calls attention to such physical limitations as would, in his opinion, influence the nature or quantity of the work the patient might perform. A renewal of his permission is required every three months.

While experience has proved that an average of sixty cases, from this school population of about 30,000, may be anticipated as active at any one time, two hundred cases in all have been referred. Data are now available for comparison of the first and the second hundred cases.

It was early apparent that the group of physically handicapped children includes the usual percentage of mentally retarded and, in addition, a number whose handicap is fundamentally mental deficiency. Indeed, the children referred for a single month ranged all the way from superior mentalities down to those requiring institutional placement. The necessity for drawing some sort of distinction in relation to mental capacity, however rough, became increasingly obvious if the best use were to be made of the facilities available.

To make certain that those best able to profit from instruction would not be neglected while questionable or definitely impossible cases cluttered up the rolls, attention has been

limited strictly to those home-bound physically handicapped persons who are mentally capable of making satisfactory progress. The application of this criterion to the various cases has been accomplished through the administration of intelligence tests. Cases to be excluded because of inadequate mental ability have been selected on the same basis as that employed by the local school child-study department. No attempt has been made to carry cases that require "special-class" placement. Through the medium of conferences, the test results in the accepted cases are made a part of the teacher's knowledge of the individual pupil.

The opinion of the psychologist has frequently conflicted with the lay public's estimate of the child's mental ability. An attractive child is often believed to be alert, his disabilities being attributed entirely to his physical condition, while tests reveal that his limited intelligence is the primary handicap. On the other hand, even the teachers themselves have had to be convinced that a child whose physical deformity gives him a queer, gnomelike appearance may actually possess learning capacities equal or superior to those of the physically more fortunate. A most interesting outcome of the program has been the changed point of view of family and friends as they have watched such a child learn to read and write, after he had been discarded as unteachable material. Their change of attitude in turn brings about a tremendous improvement in the child's own feeling of selfhood.

Case 1.—George H. was referred by the Visiting Nurse Association, who had known the family since the child's birth. At the time he was referred, George was seven and a half years old. He had a long history of illness which baffled local physicians, and he had finally been sent to Temple University Hospital in Philadelphia for study. They were unable to furnish a definite diagnosis, although they believed that the symptoms arose from "arachnoiditis." The child was dwarfed in growth, with a large head. He suffered from severe headaches, a staggering gait, and frequent upper and lower respiratory infections.

George was the fifth of eight living children, of an Irish-American family. He was given as much attention as was possible in view of the heavy household demands upon the mother and father, but he lived in the midst of a busy, exciting, noisy household, in which he felt it wise to withdraw from group participation, in physical self-protection. He talked little and seemed to have adopted the policy of making his presence as little felt as possible. The other children in the family never included him in their activities.

A Stanford-Binet test showed a mental age of 7 years; I.Q. 94.4. The performance test was somewhat below average for the patient's age, but the administration of a complete performance scale was prevented by annoyances in the home caused by the other children. The physician in charge of the case was surprised at the adequate intelligence rating. The queer general appearance of the child, together with his extreme silence—the physician had attended him for six or seven weeks and had never seen him do more than shake his head—had led to the belief that the physical disability had a mental counterpart.

It was difficult also to convince the home teacher, after her first contact with the patient, that the findings of the mental test were accurate. The boy had never attended school, and she doubted his educability. She was further distressed by the difficulty of understanding his pronunciation, which was affected by a recurrent asthmatic condition. She was, however, encouraged to establish a contact on any level at which the child seemed interested, making no attempt to introduce formally the work of the first grade.

She found that the patient loved to write. He demonstrated little skill while she was there, but would practice for hours after she had left. Given some inkling of the emotional shackles that prevented him from performing in her presence, she gave him opportunities to draw and to print the name of the word immediately afterwards. She secured crayons and other handwork material from the public school. A ray of hope showed in the child's concentration on making valentines.

Throughout, his physical condition was a distressing factor. He often showed symptoms of fatigue, to which the teacher responded by stopping the lesson and reading him stories, to which he listened with interest, showing great comprehension. He constructed sewing cards, picturing the wolf in *Little Red Riding Hood*, etc. This seemed to help his coördination, in which he had received very little practice. The teacher encouraged the older children in the family to review stories with him, and they seemed delighted with his progress. The teacher kept them supplied with books adapted to his interest level. Their growing interest in George's problem prompted them also to select proper radio programs, which he now follows. His progress in writing has been limited by his muscular inability, but in a period of seven months he has covered two pre-primers, is reading a "Here and There" book, and is starting first-grade reader. A number of coördinated books have been brought to his attention. He has made a notebook with gay wall paper pasted on the covers. Everything in it is of his own making. He is very proud of this possession. His arithmetical ability exceeds his ability in reading. He has a keen number concept. He is beginning to write sentences of his own, and the teacher's happiest accomplishment is a story which he dictated.

The teacher dates her success in breaking through George's reserve from the day when she played marbles with him. He won, laughed, clapped his hands, and for the first time initiated conversation. Before that he had spoken only when directly questioned. The teacher rapidly followed this up by a gift of a kitten, when he showed interest in the story of "Cinder." He discussed a name at great length, finally selecting "Buzz." As an example of how the family are encouraging

his use of initiative in every possible direction, he has complete care of this pet. He is making a scrapbook of pets and discusses the care of various animals. He surprised the teacher by volunteering a long explanation of the Hindenberg disaster, which he had heard over the radio. He wants her to read about the Coronation in the newspapers.

The mother has so thoroughly recognized the need of social contact for George that she suggested a party. Several children attended and they played a modified form of "Bingo," which the teacher had practiced with George in advance.

There is now no question of George's ability in the mind of the teacher, although his progress will always be limited by his undependable physical condition and his low margin of physical energy.

Unfortunately, psychological ratings can be obtained only for cases in which special diagnostic need is indicated. Every teacher, however, has had ingrained into her the need of discovering the emotional response of the individual toward the crippling condition, of asking herself: "What emotional disturbance resulting from a disabled body affects this particular child? How does it affect the parent-child relationship? What positive influence can I discover to compensate for the destructive emotional aspect?" The core of the problem sometimes lies deeper than the immediate complications of the physical handicap. Aware, however, of the threat "to such fundamental drives as self-expression, security, and attention,"[1] even the teacher untrained in psychiatric implications may do much to readjust the whole child. Proceeding from the point of view that some damage to self-esteem accompanies every physical trauma, she attempts to minimize any "feeling of difference" from his fellows that the child may have. Self-reliance is the keynote of her relationship with the child—a constant attitude of taking it for granted that he will help himself. She behaves as if he were a normal child. The patient, meanwhile, is quite unaware that she is gradually developing the potentialities which she is constantly trying to uncover in his make-up.

Progress in school work has been made secondary to the child's own need for developing a self-confident attack. A visit with each home-bound child's last classroom teacher, supplemented by the administration of a complete achievement test in cases where the child has been out of school for

[1] See *The Neurotic Constitution*, by Alfred Adler, M.D. New York: Dodd, Mead, and Company, 1926.

some time, has made it possible for the home teacher to take up the child's studies from the point at which he exhibits complete understanding and security. If he does third-grade reading and second-grade arithmetic, he is given special instruction and stimulation in the weaker subject, but his strengths are emphasized, so that he has no sense of any breath-taking effort to equalize his curricular standing. The official school syllabus has guided the teaching, but the rate of work has been dictated by the individual's mental and emotional needs, as indicated by physician, psychologist, and the teacher's day-to-day observations.

Case 2.—Kenneth H. was referred by the Visiting Nurse Association when he was fourteen years old, two years after the amputation of his right leg through the middle of the thigh, an operation necessitated by acute osteomyelitis involving both legs. The discharging sinuses kept the boy in hospital under care for a year and a half. He had been at home for three months before the institution of the Home Teachers Project. Nursing care was still required to dress the unhealed stump. A brace on his left leg made it possible for the boy to move on crutches. He was a large, heavy boy, with a quick, enchanting smile, which rapidly won him friends. During his hospitalization, he had become the pet of doctors and nurses.

The patient was the fourth of five children. His friendly spirit won him the same attention at home, from his older brothers and sisters and from neighbors, that he had received at the hospital. One brother had a truck and took the boy out daily for long rides. The sisters brought him such surprises as their meager income would permit. The mother cooked mainly for Kenneth's pleasure. The ready sympathy which had always surrounded him made it possible for him to secure a perpetual round of entertainment with no effort or responsibility on his part.

A Stanford-Binet test gave a mental age of 10 years, 11 months; I.Q. 79.8. The patient was in the 5A grade in school when he became incapacitated. His marks ranged between 75 and 80 per cent. When the principal was visited for the purpose of securing books, he doubted whether Kenneth's interest could be enlisted in any long-time serious study.

His first teacher was a motherly woman who had a daughter about Kenneth's age. She early demanded that whatever work he undertook be neatly presented in a style that would be acceptable in the regular classroom. Her displeasure at smudgy, dirty notebooks first surprised Kenneth and finally stimulated him to greater effort. He was pleased with a carefully charted map which decorated his wall. At first he was careless in the preparation of his spelling, but a game recording his scores soon resulted in increased accuracy. The teacher encouraged his interest in books on aviation. A discussion with the older brother convinced him of the need of giving Kenneth recognition for his school progress and of holding up standards toward which Kenneth might work. This brother took him to ball games and out fishing.

A great spurt of energy was apparent at a time when Kenneth took the same examinations as his class in 5A work. The principal at the school commended him on his carefully written arithmetic paper. From that time on, there was little difficulty in enlisting his interest in all academic accomplishments.

A set of letters to stencil was given him so that he might assist in making signs for the Visiting Nurse Association and other organizations that needed such help for exhibits, and so forth. He did this work with neatness and precision. It was possible at this time to send a man teacher, who was especially interested in typewriting. An old typewriter was secured, and Kenneth became so enthusiastic about this that he prepared his daily lessons on the typewriter, taking a professional pride in the general appearance of his work. He began also to take responsibility for his younger brother's school work.

All efforts to interest Kenneth in work of a mechanical nature were of no avail, but he did some painting and coloring. He took great interest in local baseball games, his activity as a spectator rivaling that of the actual players. Also he made a game resembling checkers from cardboard and match sticks, in which long-time practice helped him compete with boys of his own age.

After two and a half years of tutoring, the family moved from a home that was inaccessible to the school to a new district from which it was possible for Kenneth to go to school on crutches. A new brace was secured through the Rotary Club (an artificial limb will not be purchased until he obtains his full growth), so that he is now able to walk, with some effort.

The physician was consulted as to the advisability of Kenneth's returning to school. He felt that the boy could do so without physical damage. It was the job of the visiting teacher to convince Kenneth that this was desirable. He shrank from new contacts, but seemed keen to try his mettle in classroom competition. His brother is now in the same class, and he felt that he had superior knowledge when they did their home work together. Intellectually he was challenged. But he continued to find reasons why he could not rejoin the group until an ever later date. The visiting teacher, however, took him to school, introduced him to his prospective teacher, and discussed the advantages of a regular school education. It was decided that he should take regular classroom examinations and start school in September in the eighth grade.

The hourly teaching method has made possible great flexibility in the matter of adapting the work to the individual pupil's interests, his school requirements, and the limited activity his condition permits. The able child has been given every opportunity for an enriched program. History, for example, includes help in selecting correlated novels, map-making, notebooks, and so on. On the other hand, the slow child has worked only as fast as he could proceed with absolute confidence. Books of the same degree of difficulty have varied his work, while protecting him from attempting more than he could assimilate.

Young children who have never attended school have learned to correlate their growing knowledge of reading and writing with everyday experiences. Primary teachers, who have developed related art work, have been assigned to these cases.

Older crippled children, who had been neglected for long periods, with no instruction even in reading or writing, made up a large part of the first one hundred cases. They were eager to seize this first opportunity for an education suited to their physical disability, and grasped the first-grade rudiments with astonishing rapidity. The teacher was then faced with the need of providing simple work which would not appear too childish to these matured pupils. One illiterate sixteen-year-old girl was enabled to continue her reading development through an adaptation of the pamphlets used in Americanization classes for teaching English to foreigners. She escaped primer reading by learning through this more interesting form. She read a primer translated from the Russian, because, despite her limited reading ability, she was keen enough to appreciate the interest of the Russian experiment. She soon took pride in writing to manufacturers for samples, employing her new knowledge of writing and numbers. She also started a stamp collection, which gave her further opportunity for correspondence.

Where the child's handicap is of a temporary nature, as in the case of post-traumatic, post-operative, and similar conditions, as soon as the physician permits him to return to school, the home teacher accompanies him there, confers with the principal regarding the child's accomplishments, and introduces him to his new teacher, whom she apprises of the child's scholastic efforts during the period of home tutoring. Thus the child who has been obliged to be temporarily absent escapes the hardship of returning to find his classmates so far ahead of him as to make him feel lost. Inferiority feelings are minimized since he has kept pace with his grade. He is spared the struggle of readjusting which has proved fatal to so many school careers.

Case 3.—Gertrude F. was thirteen years old at the time when the family applied to the project for instruction. She had recovered from an attack of rheumatic fever which had necessitated removal from school

one year earlier. She now suffered from endocarditis, which the doctor definitely felt might be improved with proper rest and care, so that she would be able to return to school. It had formerly been most difficult for the patient to keep to a routine of quiet activity. However, as the doctor discussed her physical condition with her, she came to appreciate that the restrictions imposed upon her did not represent authority from without, but were limitations that must be of her own choosing if she were to return to a more normal school life. She was delighted, therefore, to be able to fit her school work into her program of physical improvement.

Gertrude was the oldest of two girls in a superior home of fairly stable economic status. Both the father and the mother had always treated the patient as an adult. She had few play interests and was expected to sit in consultation with the older members of the family on all family problems. The mother found it difficult to provide a healthy environment consistently until the patient herself determined that they should work it out together. The patient's unhappiness about her absence from school, and her fretfulness at falling behind her class, had added to her difficulties to such an extent that it almost seemed wiser to have her return to school than to let her continue to agitate herself about her inability to attend.

A Stanford-Binet test gave a mental age of 14 years, 3 months; I.Q. 107. The child exhibited superior ability in the manipulation of visual and mental imagery. With performance material, her ability was consistently "median."

At the time Gertrude left school, she was in the sixth grade, her marks averaging 85 per cent. Her school attendance from the time of entrance had been very irregular because of recurrent ill health. She attended a parochial school, which offered consistent aid to the teacher in supplying books and outlining the work of the grade. Throughout the teacher's contact with Gertrude, a great effort was made to keep abreast with the actual school work, since the child's goal was so definitely to achieve normal school progress. The patient devoted two hours a day to the preparation of the work assigned, so that every subject was adequately covered.

Before the contact was closed, the patient was given a new Stanford achievement test for grades 4–9. She was also given a Metropolitan achievement test, which indicated a rather even educational profile. She was delighted with this concrete evidence of her progress and returned to school in the seventh grade with a definite feeling of security in her academic work and in relation to the other children in the classroom.

Academic instruction gauged to build self-confidence is only one of the tools used in preparing these children to live a healthy emotional life. The teachers have proceeded on the belief that a busily occupied child is a happy child. They have provided programs of satisfying activity, carefully planned to increase the sense of accomplishment. Each child must have a chance to excel. Youngsters who have never

felt that they were capable of sewing have learned to make charming stuffed dolls and animals, not only for themselves and their friends, but for distribution to charitable organizations. Braided-leather bracelets have become a delight to a number of adolescent girls. Fascinating belts have been easily constructed. By making things for themselves and others, the children have begun to feel that they are contributing members of the family and even of society. The younger children have made friezes of circus animals for their nurseries—a long-time project that calls for planning and concentration of effort. The child's ability has been slowly built up by smaller projects until he has gained confidence in his own ability to achieve. In every home the mother has been made aware of the purpose behind the activities instituted. Many mothers soon have shown their understanding by taking the initiative in offering further suggestions as to methods of increasing the child's security and self-reliance.

Case 4.—Mildred G., ten years old, was referred by the Visiting Nurse Association as one of the first pupils in the program. She was suffering from arthritis deformans following rheumatic fever. For six months the nurse had made every effort to stimulate her interest in some activity. The patient was depressed, cried when she heard the other children coming home from school, suffered great pain, and was unable to move either her hands or her legs.

She was the second youngest of eight children of a Polish family, whose mother spoke very poor English. Her father, while unschooled, helped the child with maps, geography, and stories of the many places to which he had traveled. The older children catered to any whim, but were at a loss as to how to "comfort her." The family were receiving county emergency relief, which was budgeted to the best advantage.

A Stanford-Binet test revealed a mental age of 10 years, 10 months; I.Q. 100.7. A second Stanford-Binet administered two years later gave a mental age of 12 years, 6 months; I.Q. 97.4. The child's performance test was superior; her vocabulary about average for her age.

At the time Mildred left school, she was in the 5A grade—on the honor roll. She was very proud of her school work. She demanded a great deal of home work, which was always neatly prepared, and read avidly all supplementary assignments. After two and a half years of tutoring, Mildred has completed the work of the seventh grade. She has taken the same examinations given to children in school. A close connection is maintained with her former public school and the visiting teacher. During a period when the Emergency Education program was discontinued for one month, the school-teacher sent home daily assignments, so that Mildred kept pace with her class until home instruction could be resumed.

In 1935 it became necessary for Mildred to return to the hospital for nine weeks. She utterly refused to go. No one could gain her coöperation until it was arranged with the hospital social worker that the visiting teacher should teach her in the ward as soon after the operation as her physical condition warranted. It was the visiting teacher who finally successfully linked the coming hospital experience with the hope of greater use of her hands, which would mean greater opportunity for writing, handwork, and the many interests which the teaching program was stimulating. Mildred decided to go to the hospital.

Mildred's record shows the changes in the picture, from the child who lay helpless and despondent, unable to use her hands or move her legs, to the interested, busy child of to-day, her activity limited only by stiff knee joints. This progress, the doctor feels, is not only a triumph of medicine, but also a reflection of the child's will to use her hands and joints despite pain and of her refusal to accept herself as anything but a capable worker, an attitude created by the teacher's expectation of accomplishment.

Mildred started with soap-carving. She made Easter decorations, she made covers for her history and geography notebooks. Her art booklet is a proud possession. She early demonstrated skill in crocheting and embroidering. More recently she has designed dolls and embroidery patterns. In connection with an exhibit of such work, her name was mentioned in a newspaper, which was passed about the neighborhood by her proud family. She has shown other children how to make paper flowers. She has delighted friends with Christmas presents of pincushions and turtles made out of nutshells. She has painted silhouettes and framed them for gifts. At Christmas time she received presents from the Visiting Nurse Association which further increased her interest —one year a doll to dress, and another year a chemistry set, together with a child-life theater, for which she writes plays. The doctor felt that further exercise might improve her hand joints and coördination, and a W.P.A. piano teacher was secured. Mildred shows the same intense, keen desire to master this medium that she has exhibited in school and handwork.

Isolation from friends was contributing largely to Mildred's extreme unhappiness when the visiting nurse first called at the home. Together with the visiting teacher, the family was made aware of the importance of visitors. Children came as messengers from the teacher, bringing tests and carrying back school work for inspection. After Mildred was out of bed, the visiting teacher arranged for occasional gatherings of several pupils. She secured transportation for them and the girls spent part of their time in lessons and part in games. As soon as Mildred was able to walk around on crutches, the doctor allowed her to make short visits to nearby friends. Now that she is able to walk, an effort is being made to have her join a sewing class which is conducted three times a week a few blocks away from her home. This would not involve the strain of regular school attendance, but would prepare her for what seems to be developing into a distinct vocational bent.

At the time the case was first opened, Mildred's physical condition offered little hope of recovery. The family were resigned and were devoting themselves largely to making her last days happy. As serums

for combating the infection and removing foci wrought physical changes, the family were encouraged to stimulate Mildred to help herself. Out of their meager income they bought crochet cotton. They became alert for opportunities to bring home pictures that might interest her for her scrapbook. Mildred's excellent handwork has developed in all her sisters a real respect for her ability. Frequently they point out to visitors the many contributions that she has made to the household decorations in bureau scarfs, "Yo Yo" pillows, etc. Recently, Mildred asked the teacher to write out the melody of *Holy Night* for her, as the family wanted her to help them in group singing. Her sisters speak proudly of the good books she reads. The librarian who guides their choice has given them reason to feel that her literary tastes are of a high order.

The family now fully understands the need of equipping Mildred with a proper education for making her living. They are conscious of the tremendous change in her feelings about herself and her world, and are not unaware of the mechanisms that have wrought the improvement and the part they must continue to play in it. Mildred has said herself, "If I ever got sick again, I would not be so scared because I know that I could do a lot of things anyway." She feels that her sickness has really given her the benefit of learning much more than a normal school experience might ever have offered. She looks forward to rejoining her class in September.

A boy who learned magic tricks became so interested in this practice and in giving a performance that he forgot his self-consciousness before other people. At last *he* had something to offer! A girl who had formerly believed herself a failure became such an expert in knitting that she was able to teach the neighborhood, as well as to sell her own products. The ingenuity of the teachers has stretched to provide not only opportunities for accomplishment, but opportunities for bringing their pupils into contact with a larger social group by means of these accomplishments. A stamp collection, for example, can never remain a lone activity. Both the family and the child too often regard a handicapped individual as doomed to social isolation. The growing body of interests in other broadening fields has served as a bond to attract other children of the same age in a happy companionship. The home-bound child has had something to offer as well as to receive from these contacts.

In this attempt to direct the drives of the handicapped child away from himself to the world about him, the teacher has been obliged to discover clues to aid her in bringing about a healthy home atmosphere. What significance does the child's physical handicap hold for the mother or father?

Are they overcome with pity, with false pride, with shame, with a fierce need to compensate? Or do they already appreciate the hard way—the building of a full and useful life? A wide variation in attitude has been encountered in the parents. Usually an invalid is overprotected, catered to by all the other children in the family, and given no hope or desire for independent or constructive accomplishment commensurate with his ability. In such cases the mother finds it difficult to leave child and teacher alone. She hovers near, answering every question addressed to the child. Frequently, a discussion of this concrete situation makes it possible for the teacher to reveal other fields in which the mother is thinking and acting with the same oversolicitude. Every opportunity for engendering a will to overcome the handicap, both on the part of the mother and of the patient, is seized. On the other hand, a few eagerly ambitious mothers insist that the handicapped child shall reach a mark of perfection in all academic work. They determine that the child must compensate for the physical handicap through intellectual accomplishment.

Case 5.—John G. was referred by the Visiting Nurse Association when he was eleven years old. He had been home from school six months with a diagnosis of quiescent pulmonary tuberculosis. He was a frail-looking, "nervous" child.

The patient was the oldest of five children—the only boy. At the time the patient was referred, the mother was pregnant and determined that she would have a brother for John. The father was an unemployed electrician, who was perpetually harassed by his wife because he was a "poor provider." She demanded high academic standards from the patient and spanked him if he did not progress according to her desires. She had been restrained a number of times by the visiting nurse from returning him to school despite the doctor's orders to the contrary. She did not limit her demands for perfection to John alone, but punished the other children if they attained less than the honor roll, which she thought essential.

The mother insisted upon being in the room a great deal of the time during the home teacher's visit, to be sure that he paid the maximum of attention to everything that was taught him. She was disgusted that he had missed so much school. The child jumped every time the mother spoke to him and seemed to fear her presence. He was given no opportunity to express his own opinion, nor would the mother listen to him when he talked.

A Stanford-Binet test showed a mental age of 10 years, 5 months; I.Q. 91.2. The child's performance covered a wide range of levels and exhibited considerable scattering of successes. His vocabulary was poor, perhaps as a result of having only younger children in the house-

hold and being prohibited from play with the neighbors' boys. A retest was advised, as the results of the present test probably represented a minimum score due to emotional instability.

At the time the patient left school he was in the 5A grade, receiving an average of 80 per cent. The patient intensely disliked school, and he was very much disturbed when the home teacher was assigned. He cried and complained that he wanted an older teacher.

Early in the contact, the mother was eliminated from constant attendance during the lesson hour. An interpretation of John's mental test and his educational achievements was made by the psychologist to the mother. The home teacher continuously attempted to reinforce this understanding. All efforts were directed toward making the mother appreciate how her attitude hampered the child's mental and physical development. The teacher attempted to help carry this changed point of view over to her reaction to the other children's school work. Superficial progress was achieved, but the deep-rooted emotional tension in relation to the entire home situation distinctly called for a more careful analysis and treatment.

John's apparent negativistic attitude toward all school work yielded more easily to the teacher's treatment. He became interested in reading stories about Greek boys and other allied school subjects or about Boy Scouts and their activities. He seemed amazed that the teacher understood his profound interest in baseball news over the radio and in the newspapers, and in attendance at local games. The teacher actually understood that this absorption made lesson hours almost like extracting a pound of flesh. This attitude on the part of both the man and the woman teacher who visited him over a period of six months permitted John for the first time to express himself freely in the presence of the teacher. He discussed experiences on fishing trips, the Soap-box Derby, and picnics, which the teacher encouraged.

The period of home tutoring gave him an opportunity to equalize his achievements in various subjects. He gained an increased grasp of arithmetic fundamentals and read much more widely books of his own choosing. The principal took cognizance of the work of the home teacher to the extent of allowing John to enter 6A grade on trial after seven months of tutoring.

A great evidence of the change in the attitude of the family was their consenting to let John spend one week at a camp, to which the home teacher secured free enrollment for him. The doctor gained a greater insight into the home situation through the teacher's reports of her daily contact with the family. This doctor did much to aid the teacher in increasing the mother's understanding of the boy's mental and physicial needs as well as in developing the child's own independence and self-reliance.

The teachers not only help parents to adjust their standards and establish a greater sense of security in the child through the development of self-confidence, but they attempt to create a relationship between themselves and the parents that will lend courage and fortitude. If the young patient

is to fight the fight to health and independence, it means a daily struggle for his sympathetic parents to encourage him to effort even to the point where they seem cruel or heartless. They must believe fundamentally that the mental attitude will make or break his future. It is not enough for them to appreciate this fact intellectually; they must *feel* it and act in accordance in meeting the small problems of everyday life.

Initiation of the teachers into an understanding of these concepts, basic to all their contacts with the special children assigned to them, has been continuously carried on by means of group and individual conferences with the mental-hygiene supervisor of the Visiting Nurse Association. She has made no pretense at fashioning trained social workers from these teachers. They are selected from regular Emergency Education lists approved by the W.P.A. and are certified to teach in the grades from primary to high school. The untilled field offered them for experimentation has aroused many questions of procedure, varying from the formal routine of their training. Keen to the challenge of the problem of home teaching with this highly sensitive group, many have readily accepted the mental-health point of view. A W.P.A. summer institute further developed this approach in the staff. Only in proportion as they themselves have been convinced that the patient's handicap need be only as great as his personality limitations have they been able to imbue all connected with him with the belief that he can become a constructive, useful, and happy contributing member of society.

Weekly reports help the teachers to take stock of the many angles each case represents. These reports not only cover the individual's academic accomplishment for the week, but clarify the progress in emotional adjustment by outlining:

1. Special interests stimulated.
2. Family adjustment.
3. Social contacts.
4. Treatment of the child's mental attitude toward his physical handicap.
5. Contact with the physician.
6. Present status of the case.

An analysis of a statistical report of the first and second hundred cases may have meaning as indicative of the num-

bers and kinds of cases to be expected in a similar school population. At no time during the entire two years of the set-up has the task of obtaining a sufficient supply of students presented any problem. Rather, the contrary has been true. The history of the project is a history of constant expansion in teaching staff and facilities in an effort to keep up with the ever-increasing demand for service. From three women teachers in 1934, the number of home visitors had been increased until in April, 1937, there were six men and eight women instructors and a psychometrist. A teacher in the office, well-grounded in social-emotional principles, reviews the records, which have such important research possibilities, and maintains contact with the public. The men teachers have released many a handicapped child from exclusive petticoat influence. The personality traits of the teacher have been considered, as far as geographical location would permit, in fitting the teacher to the child.

The distribution as to source of the first and the second hundred cases referred is presented in Table 1. From this it

TABLE 1.—SOURCES OF FIRST AS COMPARED WITH SECOND 100 CASES REFERRED FOR HOME INSTRUCTION

Source	*First 100 cases*	*Second 100 cases*
1. Visiting Nurse Association.....	37	19
2. W.P.A.	11	14
3. Teachers.	29	21
4. Other agencies.	23	46
	100	100

will be seen that the Visiting Nurse Association accounted for 37 per cent of the first one hundred and as high as 19 per cent of the second hundred cases referred, indicating the importance of the rôle played by this agency both in initiating the work and in its continuance. Under "teachers" are included cases referred by teachers, supervisors, and administrators of the public and parochial school systems of the city, as well as by the home teachers themselves. By "W.P.A." is meant the various offices of the Emergency Education program, to which cases were originally referred as a result of newspaper and radio publicity or of suggestions made by teachers in their adult-education classes. The table shows also the tremendous rise in interest evidenced by the

group designated "other agencies," which includes physicians, neighbors, hospital personnel, clinics, various social agencies, and individual social workers. The increase here, from 23 per cent in the first, to 46 per cent in the second hundred cases, is evidence that the program has taken root as a vital part of the community. Referring the names of physically handicapped persons to the home-teachers office has become the natural thing to do.

Table 2 gives some interesting data regarding the physical disabilities of the first as compared with the second hundred. Cases falling into the technically ill class, which had long presented a serious problem, rushed to take advantage of

TABLE 2.—PHYSICAL HANDICAPS * OF FIRST AS COMPARED WITH SECOND 100 CASES REFERRED FOR HOME INSTRUCTION

Handicap	*Number referred*		*Number carried*		*Still receiving instruction* †	
	First 100	*Second 100*	*First 100*	*Second 100*	*First 100*	*Second 100*
Heart disease	24	9	22	6	9	5
Disease of locomotion	15	6	10	2	5	1
Rheumatic condition	9	10	9	9	5	4
Post-traumatic condition	7	21	4	18	..	2
Post-operative and convalescent condition	7	17	6	16	..	3
Nervous disease	6	7	5	5	..	2
Osteomyelitis	6	..	6	..	5	..
Allergy	3	3	3	3	..	1
Ear or eye disease	3	2	1	1	..	..
Congenital defect	3	1	3	..	3	..
Tuberculosis	4	2	4	2	2	2
Skin disease	2	3	2	2	1	2
Epilepsy	2	2	1	1	..	1
Endocrine condition	1	..	..	..	..	..
Perthes' disease	1	..	1	..	..	..
Anemia	..	2	..	1	..	1
Sarcoma of hip	..	1	..	1	..	..
Arachnoiditis	..	1	..	1	..	1
Adenitis	..	1	..	1	..	1
Pyelitis	..	1	..	1	..	1
Nephritis	..	1	..	1	..	1
Unclassified	4	3	1	2	..	1
Mental condition; no physical handicap	3	7	..	..	..	..
	100	100	78	73	30	29

* As diagnosed by attending physicians.
† At the time the paper was written, 4/20/37.

TABLE 3.—AGES AND GRADES OF FIRST AND SECOND 100 CASES REFERRED FOR HOME INSTRUCTION.

FIRST 100 CASES *

		Grades												
Age	Total cases	I	II	III	IV	V	VI	VII	VIII	IX	X	XI	XII	Ungraded
6	3	3	..	..	..	..	..	..	..	..	..	..	..	..
7	6	4	1	..	..	..	..	..	..	..	..	..	..	1
8	6	3	..	3	..	..	..	..	..	..	..	..	..	..
9	9	1	2	3	..	1	..	..	..	..	..	..	..	2
10	11	2	1	2	1	3	..	..	..	..	..	..	..	2
11	9	..	..	1	1	3	4	..	..	..	..	..	..	..
12	8	..	..	..	..	2	3	2	..	..	..	..	..	1
13	6	..	..	..	..	2	3	1	..	..	..	..	..	..
14	9	..	..	1	..	1	1	3	1	..	1	..	..	1
15	5	..	..	..	..	1	..	..	..	..	2	..	1	1
16	6	..	..	..	..	..	..	1	..	1	2	1	..	1
17	6	..	..	..	..	1	..	..	2	1	1	..	..	1
18	2	..	..	..	..	..	..	..	..	..	..	..	..	2
19	0	..	..	..	..	..	..	..	..	..	..	..	..	..
20	1	..	..	..	..	..	..	..	..	..	..	..	1	..
21 and over	3	..	..	..	..	..	..	..	..	..	..	..	1	2
Total	90	13	4	10	2	14	11	7	3	2	6	1	3	14

* In 10 cases data either on age or on grade were not ascertained.

TABLE 3.—AGES AND GRADES OF FIRST AND SECOND 100 CASES REFERRED FOR HOME INSTRUCTION—(*Continued*).

SECOND 100 CASES *

Age	Total cases	*Grades* I	II	III	IV	V	VI	VII	VIII	IX	X	XI	XII	Ungraded
6	3	2	..	..	..	..	..	..	..	..	..	..	..	1
7	8	4	3	..	..	..	..	..	..	..	..	..	..	1
8	9	2	2	5	..	..	..	..	..	..	..	..	..	..
9	6	..	..	4	..	..	2	..	..	..	..	..	..	..
10	8	1	..	..	2	2	1	..	..	..	..	..	..	2
11	3	..	..	..	..	..	2	..	..	..	..	..	..	1
12	12	..	..	..	1	3	4	3	1	..	..	..	..	..
13	4	..	..	..	..	..	1	1	1	1	..	..	..	..
14	6	..	..	..	..	..	1	3	..	2	..	..	..	..
15	8	..	..	..	..	1	2	1	2	1	1	..	..	..
16	4	..	..	..	..	..	..	..	1	2	..	1	..	..
17	7	..	..	..	..	..	..	..	..	..	..	2	4	1
18	5	..	..	..	..	..	1	..	..	..	..	2	1	1
19	0	..	..	..	..	..	..	..	..	..	..	..	..	..
20	1	..	..	..	1	..	..	..	..	..	..	..	..	..
21 and over	7	..	..	..	..	..	..	..	..	..	..	..	..	7
Total	91	9	5	9	4	6	14	8	5	6	1	5	5	14

* In 9 cases data either on age or on grade were not ascertained.

the service at the very start. Two and one-half times as many cases involving diseases of locomotion, for example, were referred in the first hundred cases as in the second hundred; while the number of post-operative, post-traumatic, and convalescent cases, usually involving handicaps of a temporary nature, jumped from 14 per cent to 38 per cent in the same distributions. One-third as many defects definitely diagnosed as congenital appeared in the second hundred as in the first hundred. The back log of chronic cases has evidently been assimilated, and the diagnoses by physicians of the handicaps of the cases now being referred substantiates the belief that fewer chronic situations may be expected in any succeeding hundred cases.

That many of these early cases had received little or no schooling before the institution of the program may be seen by reference to Table 3. Of the first hundred cases, 6 per cent of the children receiving first- and second-grade work were nine years of age or over. In the second hundred, this number dropped to 1 per cent. For some reason, the modes for both distributions fall in the fifth and sixth grades, with a marked clustering of cases in grades five, six, and seven. Scattering of ages was greater in the second hundred cases, and this group also includes three and one-half times as many cases over twenty years of age as the first hundred, but the number of cases unclassified as to grade remained the same for both groups.

The experiment, however, has revealed that the task of academic instruction is but a single aspect of the manifold problems involved in treating the total personality of the handicapped child. The development of this total personality has been the focal point on which the efforts of the teachers have been centered.

SOCIAL FACTORS IN PSYCHIATRIC PROGRESS *

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THERE is a pessimistic school of historians who subscribe to the doctrine that the only lesson we learn from history is that we learn nothing whatever from history. Fortunately, that school is rapidly disappearing. As one who regards human history as a process, as growth, I look upon the past as part of the living present. Without understanding the one, it is impossible truly to comprehend the other. While a horizontal survey of any field of human endeavor can of course teach us a good deal, it nevertheless remains essentially a superficial, two-dimensional picture. It is history—the vertical view—that provides us with the third dimension—depth. With this dynamic approach, history becomes far more than a mere flower in the garden of knowledge; intelligently studied, it becomes a potent tool for progressive action. It is in this sense that the historical approach assumes an important place in that field of human life which deals with mental illness.

One lesson that history teaches us is that psychiatric progress does not proceed in a social vacuum. In every historical epoch the treatment of the mentally ill has been generally determined by the level of social and economic development, and by the prevailing concepts of mental disease, its nature, causes, and cure. These concepts in turn have been shaped by the cultural climate of the age. To isolate psychiatric evolution from the great stream of social development is to distort it and to rob it of meaning.

The care and treatment of the mentally ill has advanced along two major lines of development—the scientific and the humane. At times, particularly within the past century, these two lines have converged and gone forward together, but for for the most part they have pursued diverse and very uneven

* Presented before the Massachusetts Association of Occupational Therapy, Boston, November 20, 1937.

paths. This paper will be concerned mainly with the humanitarian angle; within its limits only a few historical high lights can be discussed.

Psychiatric progress might be further divided into two other lines of development—theory and practice. It has been common, in historical commentaries on psychiatric history, to regard the Greek period as a sort of golden age. And true it is that a few Greek physicians made revolutionary contributions to psychiatric knowledge, contributions that were lost to civilization for centuries before they were resurrected. Some ancient physicians, like Hippocrates, Asclepiades, and Aretaeus, recognized mental disease as a natural, rather than a supernatural, phenomenon; they located the brain as the center of intellectual activity; they formulated specific remedies for the treatment of mental patients; and they attempted to classify the various mental ailments. They gave us descriptions of some manifestations of mental illness that still stand as classic; they also gave us many useful terms, like melancholia and epilepsy. It seems they had a word for everything, and even when we have to invent relatively new words, like psychiatry, we have to go to them for inspiration. But our habit of saying that "the Greeks believed this or did that," when we really mean that some particular Greek believed this or did that, has led to some distortion of historical values. Such has been our education that when one speaks of Athens in the Periclean age, one is apt to conjure up a picture of all the Athenian inhabitants in flowing robes, walking leisurely up and down the lyceum throughout the livelong day, discoursing on the eternal verities. The fact is, of course, that even in the heyday of the glory that was Greece, the average citizen was too busy at work, trying to make both ends meet, to think of spending his hours in abstract philosophizing, and a large portion of the Athenian population was composed of humble chattel slaves. Thus there has been a mistaken tendency to identify the theories of individual Greek physicians, whose imaginations leaped milleniums beyond their period, with the general state of psychiatric practice at the time. In a land where the great majority of people lived on the ragged edge of existence, lacking what would be considered to-day the barest necessities of life, the psychiatric treatment pre-

scribed by Soranus, which included theatrics, music, and leisurely voyages down the Nile, could hardly find universal application. I am reminded of the physician in Bernard Shaw's *The Doctor's Dilemma* who knew that his poverty-stricken patient needed a sea voyage or a rest at some resort, but under the circumstances could only prescribe a medicine with a high alcoholic content, to help the patient forget his troubles.

I do not wish to minimize the really great work of the Greek physicians, but I do emphasize the need to distinguish between theory and practice, between a principle and its application. To appreciate my point one has only to look about and note the great gap that exists to-day between advanced psychiatric theory and psychiatric practice in general. In viewing the historical panorama as it unfolds before us, we have to take into account the plains and valleys as well as the high peaks in order properly to evaluate progress. History must be seen *whole* to understand it; once aware of this requisite, we can proceed to apply our knowledge of the past to present-day reality and to future goals.

Probably no aspect of the story of the genus *Homo* has exhibited so shocking and persistent a record of "man's inhumanity to man" as his treatment of the mentally ill. It is difficult to realize that it took centuries and centuries to gain general acceptance of the simple idea that the insane were sick people, no different, essentially, from those suffering from so-called physical illnesses. To free mental disease from the maze of superstitions and misconceptions that have surrounded it throughout history has entailed one of the hardest and longest battles in medical history, and the victory is not yet completely won in our own day. It might be posed as an axiom that the mistreatment of the mentally ill has stood in direct ratio to the misunderstanding of mental disease.

At different stages of human development, mental illness has been commonly regarded as demoniacal possession, as a manifestation of witchcraft, as a providential retribution for sin or crime, and as a divine gift. In consequence the mentally ill have been identified as demoniacs, prophets, witches, wild beasts in human form, criminals, and, finally, as sick persons. As demoniacs, they have been subjected to elabo-

rate rites of incantation and exorcism; as witches, they have been tortured, burned, and hanged; as brutes and wild beasts they have been caged, scourged, and driven from town to town; as criminals, they have been thrown into dungeons, whipped, and chained; as common paupers, they have been confined in poorhouse "strong rooms," and "auctioned off" at town meetings to persons who bid lowest for their keep. It seems inconceivable that the medical approach to mental disease has become the dominant one only within the past century.

To comprehend the treatment of the mentally ill at any of these levels, it is necessary to take into account not only the plane of medical practice at the time, but also the social milieu. Could the identification of mental disease with demoniacal possession be explained without reference to the religious beliefs and customs of a particular period and a particular people? Could the burning and hanging of the insane as witches be understood without a knowledge of the social conditions and the cultural climate in which it occurred? Could the bidding-off of insane persons at the auction block be isolated from the general poor-relief methods of certain regions in the United States during certain periods? Of course not. Psychiatric progress through the centuries must be considered as much a part of social history as it is of medical history.

The last half of the eighteenth century witnessed a great upsurge of democracy, reflecting principally the changing economic and social relationships of men in the Western World. It found violent and dramatic expression in the two great democratic revolutions of 1776 and 1789 in America and France. The rise of the democratic spirit brought in its wake an increasing concern for the rights of the common man and for the welfare of the poor, the underprivileged, and the handicapped. The representative progressives of the period took for their text the maxim of Pope: "The proper study of mankind is man." Surveying the condition of their fellow men, they found at every turn evidences of oppression and exploitation, misery and degradation, an indifference to human suffering, and a contempt for human life. "Man is born free," cried Rousseau, "but everywhere he is in chains!" Whether man is born free is still a matter of abstract specula-

tion, but the latter half of Rousseau's figurative commentary certainly had some basis in fact. Especially was this true of a group that even the tender Rousseau did not think about—the insane. One need only glance at Hogarth's famous painting of Bethlehem Hospital in London, then known as Bedlam, to get an idea of the treatment accorded the insane even in hospitals. Hogarth's picture, the eighth in his series, *The Rake's Progress,* depicts the unhappy Rake come to a sad end, chained to the floor, stark naked, amid a scene that suggests one of the deepest of Dante's infernal circles. The treatment of the insane at the time, cruel, humiliating, and degrading, was inconsistent with the new sense of human dignity.

The early psychiatric reforms in America were peculiarly associated with the rise of democratic ideals and institutions. It is significant that the first movements toward providing hospitals for the insane, which occurred in the quarter-century preceding the American Revolution, arose in three great centers of democratic influence—Philadelphia, Boston, and Williamsburg, then the capital of Virginia. The movement in Philadelphia led to the founding of the Pennsylvania Hospital in 1751. It was the first general hospital in this country, and the first to receive mental patients for curative purposes. In 1764 an insane asylum for Boston was provided for in the will of Thomas Hancock, uncle of that John who wrote his name large in history. But this institution never materialized, and Boston missed by a narrow margin the honor of erecting the first hospital intended exclusively for the mentally ill. That honor went to Williamsburg, where the first state hospital in America was opened in 1773.

The Pennsylvania Hospital, where insane persons were received from the beginning, along with other classes of sick people, owed its foundation mainly to the activities of the Quakers of Philadelphia, and was but one manifestation of the amazing zeal for humanitarian reform then displayed by that sect. I deem it significant that the Society of Friends represented one of the earliest groups in modern times to adopt a thoroughgoing set of democratic principles as part of their religious creed. Theirs was a revolt against the feudal concepts of religion, expressed in their rejection of ornate cere-

monies, their refusal of an intermediary between themselves and their God, their adoption of simple habits and customs, their opposition to slavery, their emphasis on good works as proof of true piety, their recognition of the dignity of labor and of the rights of their less fortunate fellow men. Persecuted and martyred in the seventeenth century, they reached their apogee of influence and importance in the late eighteenth and early nineteenth centuries. There is hardly a field of social reform that does not bear some evidence of their pioneering work during this period. It was quite consistent with their concept of work as a character- and health-building force that they should be the first to introduce occupational therapy in this country. We are told that the mentally ill who were able were set at light labors such as spinning wool and flax. It might also be pointed out, in this connection, that the English Quakers who founded the Retreat at York in 1792 were the first to attempt the formulation of a system of occupational therapy, which constituted a most important part of their "moral treatment." The basic concept of occupational therapy, of course, was enunciated by Galen and was understood by Greek physicians before him.

It was the Pennsylvania Hospital that brought forth America's first psychiatrist, Benjamin Rush. While I am wary of drawing misleading analogies from chronological accidents, I find it an interesting coincidence that Rush began his thirty years of labor at the Pennsylvania Hospital in 1783, the year that marked the formal end of the Revolution. If Rush was the "father of American psychiatry," he might also be called a child of the American Revolution. A signer of the Declaration of Independence at thirty, he was thoroughly imbued with the progressive spirit of the age. Like his intimate friends, Franklin, Jefferson, and Tom Paine, he was intensely interested in the world about him, and was ever active in trying to change that world for the better. The American Revolution served as a liberating agent for a host of humanitarian reforms, and Rush was prominently identified with most of them.

Upon joining the staff of the Pennsylvania Hospital, he expressed the conviction that "the patients afflicted by madness" should be the chief concern of the staff physicians, and he himself became the first American to make a systematic

study of mental disease and its treatment, and the first to write a general treatise on the subject. One of his principal rules was that the insane should be accorded the respect and deference enjoyed in ordinary social intercourse, and he also taught that doctors should at all times be honest with their patients. He was a staunch advocate of occupational therapy, and upon his recommendation, the managers of the Pennsylvania Hospital employed persons of both sexes to serve as friends and companions of the mental patients, to participate in their activities, and to read and discourse with them. Perhaps we may consider these "friends and companions" to be the forerunners of the modern professional occupational therapist. To our generation Rush's innovations may seem quite commonplace, but to his own generation they seemed little short of revolutionary.

Rush's therapeutic system, to be sure, was far from perfect. He bled his mental patients without stint, in the belief that bloodletting was a near-panacea for all sickness. He subscribed to the widespread belief that terrorizing a patient was at times good therapy, and cited the case of an insane woman who was frightened into her wits, so to speak, when her physician threatened to drown her. Acting in the belief that he was devising marvelous therapeutic aids for the mentally ill, Rush invented two mechanical instruments—the gyrator and the tranquilizer—that could easily find a place in any modern museum of horrors.

But to gain appreciation of Rush's real contributions, it is necessary to evaluate his work against the background of the general plane of psychiatric development in his own period. Remember that in Rush's time lunatics were regularly chained and whipped at the full of the moon. Physicians still prescribed astrological remedies for epilepsy, to be applied at certain phases of the zodiac. Townspeople visited asylums on Sunday to see the "loons" on exhibition, and paid a regular admission fee for the entertainment. All sorts of torturous devices were used by contemporary "mad doctors," who firmly believed that terror was an essential part of the therapeutic process. In some European asylums patients were sent hurtling through trapdoors into icy baths below, in accordance with the theory that the shock would restore them to their senses. Even royal station gave little protection from harsh

treatment to the mentally ill. It is known that King George III of England was struck down with impunity by a common attendant during one of his periods of insanity, with the royal physician expressing full approval. A child of his age, Rush was inevitably subject to its limitations. His glory rests in the fact that he allied himself with the progressive spirits of his time, raising the level of humanity and science to new planes within his own sphere of interest and activity.

The next great American period of reform in the care and treatment of the mentally ill must be studied in the light of the New England Renaissance, extending roughly from 1830 to 1860. To paraphrase Vernon Parrington, this great awakening may be said to have resulted from the impact of the Industrial Revolution upon the social conscience of New England. Like the Revolutionary era, it was a period of great economic change, with profound shiftings of class forces. In every such period of change the conditions of human life become most sharply defined; there is pressure from below which meets with a response from sensitive individuals on all levels of the social scale. The cultural climate of New England was most salubrious, certain to bring forth rich fruit.

The social outlook of the representative men of the New England Renaissance bears many analogies to those of the Revolutionary period. Boston, while not quite the Hub of the Universe, was at least the hub of humanitarian reform, as Philadelphia had been in an earlier period. It was a radiating center of the abolitionist movement, of penal, poor-law, and educational reforms, and of great improvements in the condition of the insane. As early as 1828, Horace Mann, then a state legislator, had enunciated for the first time the principle that "the insane are the wards of the state." Mann's great educational reforms are known to all. His leading part in the establishment of the first state hospital in Massachusetts is not so well known. He was active in the founding of the Worcester State Hospital, and served on its first board of trustees. It is interesting to note that the importance of occupational therapy was recognized from the beginning at Worcester, as it had been years earlier at McLean. For a remarkable description of the basic principles of occupational therapy, I refer you to a section of the third annual report of

Worcester, published in 1835, and beginning with the sentence: "Experience has proved the vast importance of labor, and its utility."

The same intelligent management introduced at Worcester was adopted by the Boston Lunatic Hospital, the first municipal institution of its kind in America, when it was established in 1837, just one hundred years ago. The most impressive tribute to this hospital was paid by Charles Dickens in the account of his American tour in 1842. The praise lavished upon it was impressive because Dickens was familiar with the mental hospitals in his own country, and because his general impressions of American institutions were far from favorable. I should like to quote a paragraph from his *American Notes,* describing the occupational-therapy department at this institution, which he erroneously, but prophetically called the Boston State Hospital:

> "In the labor department, every patient is as freely trusted with the tools of his trade as if he were a sane man. In the garden and on the farm, they work with spades, rakes, and hoes. For amusement they walk, run, fish, paint, read, and ride out to take the air in carriages provided for the purpose. They have among themselves a sewing society to make clothes for the poor, which holds meetings, passes resolutions, never comes to fisticuffs or bowie knives as sane assemblies have been known to do elsewhere, and conducts all its proceedings with the greatest decorum. The irritability which would otherwise be expended on their own flesh, clothes, and furniture, is dissipated in these pursuits. They are cheerful, tranquil, and healthy."

All this in 1842.

This was about the time that Dorothea Lynde Dix began in Massachusetts her great crusade in behalf of the insane which carried her on a forty-year pilgrimage through every state on this side of the Rockies, across the border to Canada, and beyond the Atlantic to Europe. Her immortal achievement in bringing to the light of day the miserable conditions of the insane in poorhouses and prisons, and in forcing the erection of state hospitals, is too well known to you all to require detailed account. Suffice it to point out that she, too, was a child of the New England Renaissance. Some decades ago, when the great feminist, Frances E. Willard, was gathering material for a biographical study of Dorothea Dix, an acquaintance remarked that she thought Miss Dix was a New England woman.

"That goes without saying," Miss Willard answered. "In those early days no other woman would have dared attempt what she so gloriously performed."

Yes, Dorothea Dix could only have been a product of New England at a particular stage of its social development, even though her work reached far beyond its borders.

The third great period of reform came with the founding of the mental-hygiene movement by Clifford Beers in the early years of the present century. The great work of the author of *The Mind That Found Itself* is familiar to every one in this audience. For the purposes of this paper, it is only necessary to emphasize the fact that the founding of the mental-hygiene movement must be considered as an integral part of the remarkable wave of social reform at the turn of the century. This period witnessed the rise of great humanitarian movements in varied fields, all emphasizing the keynote of prevention.

I have skipped lightly across the centuries, trying to bring into focus only a few significant landmarks, and it is now time to draw to a conclusion. I said at the beginning of this paper that history can be used as a potent tool for progressive action, if its lessons are studied well. What are some of the lessons that can be drawn from the past by those interested in improving the condition of the mentally ill? Time permits me to indicate only a few possibilities. For one thing, we can learn that progress was never achieved by the smug and the satisfied. Too many people, in paying lip service to the pioneers of progress, in psychiatry and elsewhere, are content to rest on the oars of their ancestors. Forgetting that many of these progressives were looked upon by their contemporaries as trouble-makers, crackpots, radicals, and visionaries, some of us tend to adopt that very attitude toward the pioneers of our own time. We need more tolerance, more active support, for innovations of a progressive nature. Standing on the shoulders of past generations, ours is able to look higher and farther than they could. With the advantage of data accumulated through the centuries, we know more than they did, and knowing more, we should do more. Knowledge is power only when it is applied. For example, no one now disputes the value of occupational therapy, but all too often we find occupational-therapy departments relegated to the dark

basements and hidden corners of institutions, where effective work is difficult. There is literally a need to lift occupational therapy out of the cellar into the light of day. Perhaps the most striking example of "culture lag" that psychiatric practice affords is found in the estimate that if our present knowledge of the causes of mental disease were utilized, the rate of psychoses could be reduced fully 40 per cent. To bridge the gap between theory and practice is one of our great unsolved problems.

One more thought. Those interested in the welfare of the mentally ill and the prevention of mental illness cannot adopt an isolationist policy if they hope to pursue their aims successfully. Their vistas must be broadened to extend far beyond institutional walls. They can best attain progressive goals in their own field by actively participating in the broader social movements, driving forward toward higher levels in the true democratic tradition. In the American past, progress in the care and treatment of the mentally ill has flourished most in those periods which witnessed an extension of the democratic ideal and a heightening of social consciousness. Conversely, a society that looks on with callous indifference at the spectacle of the wanton, aimless slaughter of innocents, and the destruction of peaceful towns by air bombings, is hardly calculated to give much thought to the needs of the mentally sick or to any other groups of sufferers.

In conclusion I should like to quote from an address by one of the noblest of all Americans, William Ellery Channing, delivered here in Boston on November 12, 1837:

> "We have indeed little cause of boasting. The great features of society are still hard and selfish. The work of a human being is a mystery still hid from an immense majority, and the most enlightened among us have not looked beneath the surface of this great truth. Still, there is at this moment an interest in human nature, a sympathy with human suffering, a sensibility to the abuses and evils which deform society, a faith in man's capacity for progress, a desire to carry to every human being the means of rising to a better condition and a higher virtue. Amidst the mercenariness which would degrade men into tools, and the ambition which would tread them down in its march toward power, there is still a respect for man as man, a recognition of his rights, a thirst for his elevation. . . . We see in the common consciousness of society, in the general feelings of individuals, traces of a more generous recognition of what man owes to man."

RECREATION AS A FACTOR IN HANDLING MALADJUSTED INDIVIDUALS *

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ALTHOUGH the temptation is very great to launch into an immediate discussion of recreation as a factor in handling maladjusted individuals, I should feel more comfortable in asking you to consider with me a broader approach, so that we may be better prepared to understand each other as we go along. With this in mind, then, I am asking you to accept a few of my own definitions.

To understand what is meant by the term "emotionally maladjusted," it should be clearly stated that emotions, as I think of them, are currents which become part of all human functioning. They are like electric currents flowing from battery to bulb or from dynamo to some part of the machine. Emotions are to human life what power and heat and light are to machinery. An individual would, therefore, be emotionally balanced when his currents of power, warmth, and heat were working so well that he could meet various situations of life successfully and, if I may use the term, gracefully. If adjustment is the metabolism of human life, basic to all normal living, maladjustment is the dysfunctioning of this process, resulting in difficulties in work, love, or social contacts.

If you will accept these concepts of emotion and maladjustment, you will readily see that the forms of emotional maladjustment are as different and manifold as individuals themselves are varied. Individuals differ not only as to physical type, but even as to the type of rhythm they employ in meeting life. When the rhythm is disturbed, we say that the individual is maladjusted. We mean by this that either within the individual himself or in his social and community contacts, difficulties exist which tend to make this individual unhappy.

* Presented before the New Jersey State Recreation Executives Association, April 19, 1937.

Permit me for a moment to outline for you some of the sources of maladjustment. I should say that the first source of emotional maladjustment is to be found in the type of the individual himself—in the functioning and structure of his own body-mind. It seems to be true that almost every individual is born with one or more inferior organs. This may be in the circulatory system, in the digestive apparatus, or in the reproductive organs, but wherever the function and structure of the individual is faulty, there seems to result some fault in adjustment.

The second source of maladjustment I have found to be in the racial background. Here we know again that many people who emigrate from one country to another find it difficult to adjust themselves to new conditions. Even within the same country we often see members of old families finding it very trying to accept certain forms of dynamic living. That is why we have witnessed the growth of suburbs or areas of segregation within the city where people establish themselves in neighborhoods of the same racial or family characteristics.

The third source of maladjustment is to be found in the process of learning or what may be termed academic education. It is generally accepted that the scholastic curriculum is based on the idea that all human beings, from kindergarten to university, are able to absorb and respond to the same outlines of study and academic requirements. But experience shows that the learning capacity of one child may differ from that of another, not only as to the quantity of knowledge he can absorb, but as to variety of subject. Certainly the failure of scholastic curricula to meet these differences results in emotional maladjustment.

The fourth source of maladjustment may be found in the home conditions into which the individual is born. Many a child is born into a home environment that is not helpful to the unfolding of his own potentialities. Into a family of college graduates concentrating on academic aspirations, how often we find a child born whose best contribution to the world will not be in academic fields. Similarly, in law-abiding families we find destructive and delinquent children. We cannot say that it is the fault of the parents, and certainly it is no fault of the child, but the rhythm of living of each individual is so uniquely personal that an unwillingness on his

part to give up his own interests and fully to accept the patterns of his environment again causes first conflict and then maladjustment.

A fifth source of maladjustment is to be found in the adjustments necessitated by growth from childhood through adulthood on to old age. Any new situation that the human dynamo has to meet may be a new source or cause of emotional disturbance. Disharmony or uncertainty, whether in school, love, marriage, or job, may cause real feelings of uncertainty and unhappiness.

The sixth source of emotional maladjustment may be found in the form of the community in which we live, whether it be urban or rural. The organization of the community, the activities going on there, and the opportunities it offers make either for a greater or a lesser balancing of the emotional life as they provide leaders and outlets to meet the needs of those who are a part of that community.

Having defined what we mean by emotional maladjustment and given some attention to the sources from which it may arise, we are now ready to recognize that the particular tendencies of the individual, as well as his interests, his goals, and his general environment, are of great importance in the establishment of emotional balance. To the degree to which we understand that individuals cannot be placed in categories merely descriptive of their obvious characteristics, and that latent interests, unused abilities, functional disturbances, and temperamental reactions are of the greatest diagnostic value —only to that degree can we hope to guide successfully and to adapt the situation to meet individual needs.

Let us look at a few accepted methods in the handling of emotional maladjustment. We think immediately of the use of the home, the school, the psychiatrist, the psychologist, the social agency, and so on. Depending on our economic status as well as our knowledge of community resources, we have always thought of handling emotional maladjustment in terms of clinics, sanatoria, visiting teachers, visiting nurses, special schools, and a whole battery of agencies well known to you. I wish to make my feeling in this matter very clear. I am fully aware of the value of your present varied approaches in diagnosing, guiding, and treating maladjusted individuals. But I am also aware of the great limitations put upon you by

pressure of time and general economic conditions. We must consider the relative resistance to change that most homes offer; the conditions of overcrowding and the time limitations in schools; the tendency to use a diagnostic label as an end in itself rather than as a point of departure for treatment.

Now let us look at a new—and yet very old—tool in the handling of emotional maladjustment. Let us remember that recreation is not a superimposed technique of living, but a very old law of life itself. We find it expressed in various ways throughout the history of man. In the rest and vegetation periods of plant life, we see nature using recreation as a tool. In animal life we have only to spend a day with a herd of cattle to see animal life recreating itself. Man, too, has an old and long history in his use of recreation. At different times and through different periods, it has been used differently. In recent times recreation has become identified with relaxation and leisure. Unfortunately, however, leisure still tends to be the right of a privileged group only, and so it becomes our great concern not only to enlarge the group that is privileged to enjoy recreation, but to multiply the forms and experiences of recreation. Must we not also see that even if we were to be able to give leisure to 50 per cent more of the population, a knowledge of how to use this leisure would be wanting? We are, therefore, to-day talking of a most important need of modern life and focusing our attention on how we may develop recreation, not only as a resource that is complementary to the other tools now used, but as a dynamic, integral part of life.

A cardinal principle which seems to me of tremendous importance is that recreation can never be found separated from occupation, vocation, or what is generally termed work. We all know that work is a blessing and a natural need of the normally functioning human body—just as natural as food, water, sunshine, or sleep. The plan of nature calls for a healthy body plus work and recreation. Theoretically, work was always meant to be creative or productive of something within the capacity of the individual. But, instead, we find that it tends to become only a means of making a living, a drudgery.

Recreation, therefore, becomes a necessity as a matter of mental health and social adjustment. It is true to an amazing

extent that people who are using creativeness in their daily work do not really need recreation, in its ordinary meaning, except for occasional replenishment of their energies through food, air, sleep, and social exchange. Whereas, for people whose energies are used mechanically and uncreatively, recreation becomes a matter of absolute necessity, of life and death. We find among industrial workers, the white-collar class, laborers, houseworkers, nurses, teachers, and social workers a constant need to create something—something outside of their daily work. For them it is not sufficient to supply activity programs; neither is it enough to offer lectures and courses called "Adult Education," although no one denies the value of such things. I feel very keenly that recreation must be something more, something more personal and essential to them. Here one thinks of gardening, the raising of poultry, the care and breeding of animals, wood-carving, modeling, pottery, weaving. Sometimes learning to play an instrument, choral singing, taking part in a play, dancing, photography, painting, interior decoration are among those personal experiences which may be used so effectively as recreation. Over and over again it has been shown to be true that workshops rather than lecture rooms result in deeply satisfying recreational experiences.

When one thinks of recreation specifically, and not generally, one differentiates between recreation for the adult and recreation for the child. Here, again, it is to be understood that every period of life—the pre-school period, adolescence, middle age, and old age—has its own needs which must be understood from the recreational point of view.

Let us consider for a moment the recreational needs of the adolescent, whose energies must be utilized. The adolescent has been analyzed as an individual detached from the social group as a whole, but the solution of his adolescent problems must be found in terms of group activity. Youth tells us this itself by organizing into groups of gangs, scouts, secret societies, and so on, when left alone to its own resources. Proper leadership ought to foster these expressions through mass meetings, either in school buildings or in large public halls. Here registration should be made, the young people being asked about their interests and desires, how they would like to spend leisure time, what their past experiences in recreation

have been. Then large tracts of land should be offered for cultivation, woodland for clearing and for the chopping down of dead trees, and an opportunity should be given to construct buildings on these tracts. What joy and readiness for these projects I have seen! Boys want to feel their muscles grow and to go home with the feeling of achievement. For those who show interest in collecting stamps, coins, stones, insects, or plants, recreation leaders should be not only available to guide these interests, but alert to anticipate such needs even if unexpressed. Subjects such as wood-carving, pottery, metal and leather work, weaving, painting, and drawing, call for studies with competent teachers and usable materials. Choral singing, the playing of musical instruments, group or solo dancing, and so forth, all meet the daily needs of the adolescent. Exhibitions, recitals, pageants should be given frequently so as to give youth its opportunity to show off in a wholesome and legitimate way. I have developed my own phrase for this—"legalizing illegal impulses." We all recognize that the expenditures on such a program would cost the community far less than the time wasted, the money spent, and the human energies expended in repairing maladjusted youth.

Adolescent needs for recreation can be handled on a group as well as on an individual basis. I am thinking here of an experiment that took place under my supervision and guidance in a large public school in Lee, Massachusetts.

In this school of nine hundred children, from two hundred to three hundred children were found to be anxious to get together every Saturday morning to take part in creative adventures of the kind I have been describing. Officially, the experiment was called "the hobby classes." Through the period of a school year (nine months) the children gathered every Saturday morning in an old gymnasium, distributing themselves as they wished at separate tables, covering about twenty different arts and crafts. In the middle of the floor gathered those who were not interested in manual expression, but were interested in physical activity as developed through folk dancing, ballet dancing, and the like. Around the piano gathered those who were interested either in choral or solo singing. Others were working on puppets, marionettes, wood- and soap-carving, painting, drawing, book-binding, modeling,

embroidering, crocheting, and so forth. Out of this group a professional company of puppeteers was established which is still active and successful. Many of the children still continue these crafts and artistic interests in their homes. During the winter of 1935–36 a public demonstration was given before an audience of several hundred people. Parents, teachers, and community leaders all took part in the fascinating recreational project.

I have kept you waiting a long time to share with you my own experiences in the use of recreation as a technique in solving emotional maladjustment. I hope you recognize that I have done this purposely so that all of us may focus our energies and talents on the use of recreation as a tremendous unrecognized force in the prevention of maladjustment. You will remember that I used as an illustration a moment ago individual as well as group work with adolescents in this preventive sense. If we now think in terms of recreation as a remedy for already developed maladjustment, I should like to have you consider this principle—that recreation as a technique in handling already developed maladjustment is the process of redirecting into creative and satisfying channels energies that are functioning in a disintegrating manner. I have a number of illustrations for you to consider in terms not only of the described situation, but also of the underlying concept.

I recall an individual who had to handle or touch everything that came within his sight. When there were not enough things around him, he began to annoy and tease people. It occurred to me that plastecine and clay are interesting materials which human hands may handle, form, transform, mishandle, in a constructive way. It was pliable, plastic material; it gave in. And sure enough as soon as this material was put into the hands of that individual, he discovered that there was such a thing as satisfying the desire to press, form, and handle something without harm and injury, alone and with great personal satisfaction. This discovery of a legitimate means of satisfying his own impulses led this individual into many other forms of adjustment and education.

I remember another individual who loved to inflict pain either through his talk or by physical aggressiveness. In this case hammering metal with proper tools and wood-carv-

ing satisfied his repressed emotions to such an extent that his antisocial behavior ceased.

The need to make faces, to stick out one's tongue, and the displaying of deformities of the extremities suggest the fostering of fantastic or descriptive dancing; dramatic interest and a desire to act may be another outlet for such evidences of maladjustment. We must recognize that by releasing through drama, pantomime, mimicry, and comedy the surplus energy that lives in antisocial forms, we legalize the need and provide a satisfying and stimulating reaction in the individual.

One thinks in this connection of the individual of a type frequently encountered, who is lonely and maladjusted as to his social amiability, given to sulkiness or daydreaming or bookishness. Experience shows us that a successful start in reorienting him may be made if he can be helped to transfer the energies he consumes within himself to something in the real world outside of himself. The dreamy girl who sits for hours looking at far-away hills is offered a little patch of land where she tries to raise a few flowers. Watered and nursed, the flowers finally grow, and soon she approaches us with a gift—a handful of posies. Others soon receive gifts from her garden, too, and finally we see her sufficiently cured of her former interest exclusively in herself to become the leader of a small class in gardening.

One more example—it is difficult to resist going through the long list of those whom I have seen grow strong and well on the wings of recreation. I remember clearly a young woman who came to me in a most unhappy frame of mind and in a miserably run-down physical condition. A competent housewife, an energetic mother, a devoted wife, she was finding herself at the time of our first contact full of resentment as to her duties at home, irked by the business demands on her husband, and irritated by her youngster's vivacious personality. She was tired of planning meals, washing dishes, darning socks, and asking her husband "how everything was." She had lost her interest in keeping her hair orderly; she didn't care whether she said "good morning" or not to her next-door neighbor. She knew well enough that the possibilities for helpfulness were numerous, but was too indifferent, it seemed, to care to do anything about it.

We recognized from the start that some medical care was needed. We also helped her husband to appreciate the part that physical fatigue played in her mental and emotional maladjustment. We released her for three hours each afternoon from every care and worry. But in addition to providing her with leisure, we learned that from the time she was fifteen years old she had always wished that she could study music. A piano was found and some old music books were dug out of a trunk. First an hour a day, then two and three were spent at the piano. The end of one year presents a new picture. Housework is done efficiently and willingly; a system of meal planning and preparing has been developed which permits a two-hour free period every afternoon for piano or for attendance at an occasional concert. Even the baby has been heard to pick out a few notes while his mother cooks or sews. Our friend has released from within herself a tremendous current of unused energy. She has "re-created" herself through recreation.

Many of you in the recreation field could give similar or even more striking examples. All of you will agree that one must recognize the emotionally maladjusted individual for what he is when we find him or when he comes to us. Further, we would probably all agree that the sources of maladjustment are numerous, the forms it takes equally diverse, and the methods of treating it varied. I am asking you to-day to consider particularly with me that aspect of the use of recreation as a factor in treating maladjustment that focuses attention on the *personal, intimate* creative experience which every individual wants to enjoy, but which so few realize. I must remind you again that I thoroughly appreciate the value of all kinds of recreational activity as we ordinarily see it developed in communities. The baseball game, the scout club, the group sports in which competition is modified—all of these are valuable, even indispensable aids in the building of wholesome personalities. But especially in the consideration of the treatment of emotional maladjustment through recreation, I strongly urge you to recognize the dynamic forces that lie concealed in each of us—forces that yearn for expression through personal experiences of creativeness, whether they be through the finer coördinations of the hands, in painting,

modeling, or collecting, or the larger coördinations of the body, in the dance, the drama, or outdoor work.

I know that my time is up and I should close. Yet since I am the speaker and you are my prey, I am tempted to hold you for one moment more while I exhort you to think of one more angle in our consideration of this problem. All of you here to-day are actively engaged either in the recreation field or in some allied realm. Does it sometimes occur to you that if we are to believe in the value of creative personal experience for others, we must enjoy these experiences ourselves? How many of you here to-day have experienced the personal glow of recreating yourselves through a minuet, an hour at clay-modeling, or an afternoon with paint and brush and easel? I hope each and every one of you wishes for this, but I am afraid only a few of you have felt the glow of actual experience. As a dancer of the minuet, as a gardener of flowers, as a worker with clay—and as your friend and co-worker—I greet you and exhort you, not only on behalf of those whom you help professionally, but on behalf of your own health, growth, and happiness, to embark immediately on the glorious adventure of creative personal experiences through recreation.

THE SOUTH DAKOTA PROGRAM OF SOCIAL CONTROL FOR THE MENTALLY DEFECTIVE

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THE South Dakota program of social control for the mentally defective has a twofold purpose: (1) to provide for the well-being of the mentally defective, and (2) to prevent their procreation. This program includes the following important phases: (1) Identification, (2) Classification, (3) Registration, (4) Education, (5) Segregation, (6) Sterilization, (7) Prevention of Marriage, and (8) Supervision. The first three of these phases have already been presented in MENTAL HYGIENE.[1] They will be referred to in the summary at the end of this article. The other five phases are discussed here.

The report is based on the findings of a study [2] of the methods and results of social control of the feebleminded in South Dakota. The program is fostered by the South Dakota State Commission for the Control of the Feebleminded.

Education.—There has been considerable lag in the provision for special education for mental defectives in South Dakota. Most of the cities and larger towns have had classes for subnormal children at some time. However, the need for economy, the lack of trained teachers for this work, and unsuccessful administration are the main reasons ascribed for the discontinuance of such classes. At the present time only three cities—Sioux Falls, Vermillion, and Milbank—have special classes in operation. Individualized instruction is found in many rural schools and small towns, but it is due entirely to the initiative of individual teachers. A number of county superintendents at the present time request their teachers to

[1] See *The South Dakota Mental Survey as a Basis for Social Control of the Mentally Defective*, by J. H. Craft. MENTAL HYGIENE, Vol. 20, pp. 630–45, October, 1936.

[2] *Social Control of the Mentally Defective in South Dakota*, by J. H. Craft. (Field Study No. 3.) Unpublished Doctor's thesis presented at Colorado State College of Education, Greeley, Colorado, 1937.

record mental defectives as "unclassified" and to give them individual instruction. Such a classification is entered upon the record only after a mental examiner has tested the pupil.

The state commission, in coöperation with the department of public instruction, the superintendent of schools, and the heads of divisions of education in the university and the colleges of the state, is now working on a program for special classes and individualized instruction for rural and small-town schools. This proposed program includes the following provisions: (1) legislation giving the department of public instruction power to organize, regulate, and supervise special classes in city schools and individualized instruction in small school units for subnormal children; (2) state assistance to schools that have such a program in operation; and (3) training for teachers of special classes, and the requirement that all grade and rural teachers shall take courses that will aid them to understand the psychology of the subnormal child and enable them to give him profitable instruction.

Segregation.—Segregation is the oldest phase of control of the mentally defective. South Dakota's institution, the State School and Home for the Feebleminded, is located at Redfield. During the thirty-four years since its opening, 1,836 patients have been admitted. Several hundred other applicants have been turned away for lack of accommodation.

On January 1, 1937, there were 656 patients enrolled at the State School and Home for the Feebleminded. A classification of these patients by sex and intelligence level is given

TABLE 1.—SEX AND INTELLIGENCE LEVEL OF PATIENTS * AT THE SOUTH DAKOTA STATE SCHOOL AND HOME FOR THE FEEBLEMINDED, JANUARY 1, 1937.

	Male	*Female*	*Total*
Idiot	63	57	120
Imbecile	167	122	289
Moron	116	78	194
Border-line	20	15	35
Dull	7	4	11
Average	5	1	6
Superior	...	1	1
Total	378	278	656
Rate per 100,000 of the general population †	108	86	96

* Including 94 epileptics.

† According to the South Dakota State Census Report of 1935, the total state population was 675,082, of whom 351,163 were males and 323,919 females.

in Table 1. The enrollment includes 94 epileptics, most of whom are feebleminded, though there are some of average intelligence. One of them has an I.Q. of 130. The ratio of the segregated patients is 96 per 100,000 of the general population of the state.

The registry of the state commission contains the names of 336 idiots, 1,165 imbeciles, and 4,476 morons. If in each of these classifications we compare the number registered with the number segregated as given in Table 1, we find that 6 per cent of the feebleminded registered and 18 per cent of those segregated are idiots; 19 per cent of the registered and 44 per cent of the segregated are imbeciles; and 75 per cent of the registered and 30 per cent of the segregated are morons.

The distribution of the patients at the institution according to age and sex is given in Table 2. The youngest patient is

TABLE 2.—AGE AND SEX OF PATIENTS * AT THE SOUTH DAKOTA STATE SCHOOL AND HOME FOR THE FEEBLEMINDED, JANUARY 1, 1937.

Age	*Male*	*Female*	*Total*
0–9	25	12	37
10–19	127	61	188
20–29	69	59	128
30–39	63	56	119
40–49	51	52	103
50–59	32	22	54
60–69	7	9	16
70–79	3	6	9
80–89	1	1	2
Total	378	278	656
Mean	28.52±.55	32.66±.59	30.27±.43
Standard deviation	15.92±.39	14.61±.42	16.21±.30

* Including 94 epileptics.

three years old and the oldest is eighty-four. The mean age is 28.5 years for the males, 32.6 for the females, and 30.3 for the total.

Institutionalization provides for the well-being of the patients. For economic reasons, however, the number affected by this method of control is limited. Of the total number of registered mental defectives, 11 per cent are in the institution for feebleminded in South Dakota at the present time; 62 per cent of the idiots, 41 per cent of the imbeciles,

and 10 per cent of the morons have been patients at the institution at some time. There is no established criterion by which it can be determined who should be segregated. The governing board of the institution, however, has regulations as to order of preference in the admission of patients. They are admitted on the basis of individual needs and in the following order: (1) those who are a menace in the community; (2) those who are a serious burden in the home; (3) orphans and homeless patients; (4) other mental defectives who are neglected by their relatives.

The findings of the mental survey have left no doubt in the minds of officials and informed persons as to the need for expansion of the building program at the state institution.

The public in general is well aware of the services of an institution in the custodial care of the mentally defective. The training that the patients receive at such an institution is also appreciated. There are many who consider that segregation is as well an important means of preventing the procreation of the feebleminded. They contend that segregation during the reproductive life of the patient serves as a means of prevention. This contention is, however, nullified by two practical limitations: (1) of the high-grade defectives who are the real eugenic risks, only a small portion are segregated; and (2) those who are placed in the institution are likely to be discharged early in life. The majority of low-grade defectives are segregated and do remain in the institution, but their procreative rate is small. These facts can be demonstrated clearly by a study of the turnover of the South Dakota institution for the past ten years.

We will consider first the data on intelligence level and age at time of discharge from the institution. Table 3 gives these data for the patients discharged during the past ten years. This table shows that 272 patients were discharged during this period. The mean age at time of discharge was 20.7 years. These patients were discharged early in their procreative lives. In a recent study of 73 married mental defectives in South Dakota, it was found that they had married at a mean age of 22.7 years. Thus we find that on the average the patients were discharged at an earlier age than that of the marriage of a similar group. We may note further that in the group of discharged patients, only 25, or 9 per cent, were

idiots; 84, or 31 per cent, were imbeciles, and 163, or 60 per cent, were morons. It is, therefore, the morons who are discharged to return to the community at such an early age that their propagation is scarcely hindered by this early sequestration.

TABLE 3.—INTELLIGENCE LEVEL AND AGE AT TIME OF DISCHARGE OF PATIENTS DISCHARGED FROM THE SOUTH DAKOTA STATE SCHOOL AND HOME, JULY 1, 1926–JUNE 30, 1936.

Age	*Total*	*Idiot*	*Imbecile*	*Moron*
0–4	4	..	..	4
5–9	24	9	10	5
10–14	52	6	18	28
15–19	83	6	26	51
20–24	42	2	10	30
25–29	22	2	4	16
30–34	14	..	3	11
35–39	12	..	5	7
40–44	8	..	3	5
45–49	7	..	3	4
50–54	3	..	1	2
55–59	1	..	1	..
Total	272	25	84	163
Mean	20.71±.41	13.90±.84	20.89±.85	21.67±.58
Standard deviation	10.14±.29	6.25±.59	11.55±.60	11.03±.41

Second, the effectiveness of institutionalization as a preventive measure may be further challenged after a consideration of the mental rating and mortality of the patients of the institution. Table 4 gives the data on intelligence level and age at time of death of these patients. It shows that 205 patients died at the institution during the decade 1926–1936. Of this group 92, or 45 per cent, were idiots; 81, or 39 per cent, were imbeciles; and 32, or 16 per cent, were morons. In contrast to the morons, who tend to be discharged at an early age, the idiots are likely to remain in the institution until they die. Death came to this group of idiots at a mean age of 25.4 years. The imbeciles died at a mean age of 37.5 years, and the morons at 33.9 years. This small group of morons died at a much earlier age than is ascribed to morons in general, whose mortality rate has been found to be nearer that of the general population.

TABLE 4.—INTELLIGENCE LEVEL AND AGE AT TIME OF DEATH OF PATIENTS WHO DIED AT THE SOUTH DAKOTA STATE SCHOOL AND HOME FOR THE FEEBLE-MINDED, JULY 1, 1926–JUNE 30, 1936.

Age	*Total*	*Idiot*	*Imbecile*	*Moron*
0–4	5	4	1	..
5–9	15	10	4	1
10–14	20	15	4	1
15–19	35	15	11	9
20–24	27	14	11	2
25–29	17	8	6	3
30–34	21	8	9	4
35–39	9	1	5	3
40–44	10	5	3	2
45–49	6	2	3	1
50–54	4	1	2	1
55–59	5	1	4	..
60–64	8	2	5	1
65–69	6	3	2	1
70–74	12	1	9	2
75–79	3	2	..	1
80–84	2	..	2	..
Total	205	92	81	32
Mean	31.52±.95	25.43±1.25	37.50±1.61	33.90±2.25
Standard deviation	20.34±.67	17.86±.81	21.50±1.14	18.95±1.59

A summary of the number and percentages of first admissions, discharges, and deaths at the institution during this same ten-year period is given in Table 5. This table shows

TABLE 5.—INTELLIGENCE LEVEL OF FIRST ADMISSIONS, DISCHARGES, AND DEATHS AT THE SOUTH DAKOTA STATE SCHOOL AND HOME FOR FEEBLEMINDED, JULY 1, 1926–JUNE 30, 1936

	Total		*Idiot*		*Imbecile*		*Moron*	
	Number	Per cent	Number	Per cent	Number	Per cent	Number	Per cent
First admissions	624	100	108	17	242	38	274	45
Discharges	272	100	25	9	84	31	163	60
Deaths	205	100	92	45	81	39	32	16

that a total of 624 first admissions were made during this period. Of this group, 108, or 17 per cent, were idiots; 242, or 38 per cent, were imbeciles; and 274, or 45 per cent, were morons. The number and percentages of the discharged and dead have already been given. This table brings together the classification of these groups and helps to clarify the fact that

there is a tendency to discharge morons at an early age and to retain idiots at the institution until death.

Sterilization.—Selective sterilization has been practiced in South Dakota since the opening of the institution hospital in 1929. A few operations had been performed prior to this date in private hospitals, and 11 vasectomies were performed at the institution in 1921. The first sterilization law was enacted in 1917. This law was amended in 1927 and again in 1935. The law applies only to the feebleminded who are of procreative age. In its practical application, only those who seem likely to become parents are selected for sterilization. Patients who are expected to remain in the institution permanently, those who are well supervised, and those whose physical condition is such that procreation appears improbable, are not sterilized.

The method of sterilization is vasectomy for males and salpingectomy for females.

Up to January 1, 1937, there had been 304 sterilizations in South Dakota. Of this number 110 were males and 194 were females. Ten had died since they were sterilized. Of the rest of the group, 88 were married, 6 were divorced, 8 were separated, 7 were widowed, and 185 were single. The ratio of sterilizations to the whole population of the state is 43 per 100,000.

The age of the patients at the time of sterilization is given in Table 6. The mean age of the males was 25.4 years; the

TABLE 6.—SEX AND AGE AT TIME OF OPERATION OF PATIENTS STERILIZED IN SOUTH DAKOTA, 1917–1937.

Age	*Male*	*Female*	*Total*
10–14	3	13	16
15–19	43	73	116
20–24	26	34	60
25–29	9	29	38
30–34	12	19	31
35–39	4	17	21
40–44	6	9	15
45–49	3	..	3
50–54	2	..	2
55–59	..	..	..
60–64	2	..	2
Total	110	194	304
Mean	25.35±.68	23.91±.35	24.41±.36
Standard deviation	10.70±.48	6.92±.25	9.05±.25

mean age of the females, 23.9 years. For both sexes combined the mean age was 24.4 years. The mean age of the single patients at the time of sterilization was 18.7 years. The single patients were sterilized about four years below the average age when such persons are married.

Of the males 20 had been sex offenders before sterilization. One has repeated the offense since the operation. One male has become an offender since sterilization. Eighty-nine of the 194 females were offenders prior to sterilization; fourteen of these have repeated the offense. Two of the 194 have become offenders since the operation. The total number of sex offenders prior to sterilization was 109. The number of those who have been offenders since the operation is 18. The ratio between the number of offenders prior to sterilization and the number since is, therefore, 6 to 1. The mean time since the sterilizations were performed is 4.7 years.

Two males and five females had acquired a venereal disease before sterilization. Three new cases of such infections have been found among the females since the operation.

The reduction in sex offenses after sterilization was undoubtedly due to supervision and the discipline imposed upon these patients and their relatives. At the time of commitment or consent for sterilization, the patient is placed under the supervision of the state commission. The delinquent patient hears his offense stated for the record, and the operation that follows seems to him to come about as a consequence of his offense. If he tends to continue offending, he and his relatives are warned against such conduct. If he still continues, he is committed to the institution. After a time he may be paroled on good behavior. If his offenses continue, his parole is revoked and he is returned to the institution. The younger patient usually prefers to be at large. If his relatives are not too defective themselves to assist him, his permanent segregation may not be required. There are instances, however, where the moral influence in the home is so negative that the patient has little chance for success on parole.

Legal authority for sterilization may be obtained through the consent of relatives or by order of the subcommission for the control of the feebleminded of the county in which the patient resides. Of the 304 sterilized patients, 173 were oper-

ated upon by consent; 102, upon the orders of subcommissions; and 29, by consent and waiver of orders by subcommissions.

According to a South Dakota statute, the subcommission may commit any person for sterilization who is found upon investigation "to be feebleminded and of such an age as to be capable of procreation; that by reason of feeblemindedness said person would not be capable of properly performing the duties of parenthood." In addition to the incapacity for good parenthood given in the law as the reason for sterilization, there is the additional reason of the risk of morbid heredity in a large number of cases. As a means of prevention of procreation, sterilization probably has been more effective than any other phase of social control in the state. In this single purpose, one treatment is final. It is certainly inexpensive.

Prevention of Marriage.—The prevention of marriage of the mentally defective is a simple procedure in South Dakota. In accordance with the statute, the state commission furnishes each county clerk with a list of the feebleminded who have been committed to its control. The clerk "shall not issue a marriage license to any party whose name appears upon lists submitted to him, unless satisfactory evidence is furnished that one of the contracting parties has been sterilized or is otherwise incapable of procreation."

A total of 1,449 patients—799 males and 650 females—were committed to state control during the first five years of operation of this law. According to classification by intelligence level, 71 were idiots, 611 imbeciles, and 767 morons. The commitments have averaged 290 per year. These 1,449 commitments include 26 per cent of the 5,977 that were registered during the past eleven years. The ratio of commitments is 215 per 100,000 of the whole population of the state.

The age distribution of the 1,449 patients at time of commitment is given in Table 7. The age varied from one to sixty-seven years. The mean age at time of commitment was 21.4 years. This is below the mean age at which mental defectives marry. After the first years of operation of the law, the age of commitment will be likely to be lower because there will be fewer older persons to be committed.

TABLE 7.—SEX AND AGE AT TIME OF COMMITMENT OF PATIENTS COMMITTED TO THE SOUTH DAKOTA STATE COMMISSION, JULY 1, 1931–JUNE 30, 1936.

Age	*Male*	*Female*	*Total*
0–9	73	52	125
10–19	392	309	701
20–29	187	166	353
30–39	78	71	149
40–49	45	38	83
50–59	20	11	31
60–69	4	3	7
Total	799	650	1,449
Mean	21.29±.21	21.60±.29	21.44±.20
Standard deviation	11.63±.11	11.18±.21	11.41±.14

Although the South Dakota law relating to the prevention of marriage of the feebleminded is direct, and the procedure for its enforcement is simple, it has not been completely effective as a means of prevention of marriage. There are two ways in which it has been evaded: (1) patients have gone into other states for marriage; and (2) nonfeasance of county officials has opened another loophole. In a recent preliminary investigation in eighteen counties, the social worker found that seven patients, after being refused licenses in South Dakota, went into surrounding states and were married. One clerk granted a license illegally, and in another case the original order of commitment was not filed by the subcommission. As a means of redress in these nine cases, the state commission started proceedings to obtain the sterilization of these patients or their spouses in the cases where the spouses were also feebleminded. One patient has been sterilized. The husbands of two of these patients consented to sterilization to save their wives a more serious operation. A third patient was able to produce evidence of a sterile union. Action is still pending for the operation of the other five.

To prevent further instances of nonfeasance, the state commission now sends a representative to check the clerks' lists, and certification of these lists is required to prevent evasion of responsibility. Furthermore, the clerks are warned against neglect in this matter. To avoid the recurrence on the lists of persons whose commitments are not filed, a certified copy of the original is required before the patient is listed.

Supervision.—When a mentally defective person is committed to the supervision and control of the state commission, he becomes a ward of the state and, in accordance with the law, the responsibility for his supervision is shared jointly by the state commission and the subcommission of the county in which he resides.

The subcommissions in most counties, however, have very limited facilities for supervision. They also have been slow in making use of the welfare agencies that could be of much assistance. The state commission, too, up to this past year, had neglected this phase, while busily engaged with the continuous census and with new commitments. When it was discovered that some of the wards of the state were being neglected, and that the anti-marriage law was not being rigidly enforced because of carelessness in some county offices, the commission employed a trained social worker as supervisor of this group.

The duty of the supervisor is to represent the state commission in its twofold duty to each ward of the state—that is, to see that provision is made for his "well-being" and to "prevent his procreation."

Dr. F. V. Willhite, chairman of the state commission, recently outlined the purposes of supervision in the South Dakota program.[1] He suggested certain minimum essentials to be gained by supervision.

One of these is to see that the patient is protected from abuse and gross neglect. Abuse of the patient in the home is rare, but when it does occur, it is the duty of the supervisor to start proceedings to remove the patient from the home or to see that conditions in the home are improved.

A second essential is to make sure that the patient is provided with the necessities of life. A number of the patients are partially or entirely dependent. They do not always make their needs known to local welfare agencies. The supervisor can assist them to make their real needs known.

The assurance of educational opportunities is a third essential responsibility. The supervisor sometimes has the opportunity to bring about a better understanding between the

[1] See Sixth Biennial Report of the State Commission for the Control of the Feebleminded, 1934–1936.

school and the home. The imbecile gets little value from school and may be a hindrance to others. Here the supervisor can explain the real difficulties to the parents and persuade them to keep the child at home. If necessary, action can be obtained for the exclusion of the child from school.

The employment of the patient is a fourth essential service to the patient—that is, if he is able to work and if employment is available. Here, again, the patient needs some one to speak for him.

A fifth essential service is the appointment of legal guardianship if he has property or other wealth. Too often, unscrupulous persons, even relatives, are allowed to defraud the patient of his means. The supervisor can initiate proceedings to obtain such guardianship.

It is not to be expected that ideal surroundings will automatically accrue to the mental defective because of the provision for supervision, but the fact that this service is provided demonstrates that the state is endeavoring to meet its obligation to its wards and that efforts are being made to make available to them whatever facilities there are in the community and the state.

The supervisor will maintain a continuous check-up on the patients under state control. She will keep the commission informed of evasions of the anti-marriage law, so that action for sterilization may be started promptly. This applies to illegitimate sexual relations as well.

SUMMARY

The South Dakota program for the social control of the mentally defective has a twofold purpose: (1) to provide for the well-being of these defectives; and (2) to prevent their procreation. The eight phases of this program—which consists of the most practical methods known up to the present time—and some of the more outstanding features of each, are as follows:

Identification.—The identification of the mental defective is the first step in a program of control. The facilities of schools, social agencies, health centers, institutions, teachers, social workers, physicians, nurses, officials, clergymen, and other

individuals aid the field workers of the state commission to locate the mentally defective.

Classification.—After the mental defective is found, a mental examination is made in order to determine his intelligence classification. Mental examiners are employed for this purpose. Over fourteen thousand subjects have been examined in the state. Of this number over six thousand have been given a preliminary rating of feebleminded.

Registration.—A central registry is necessary for the efficient working of a program of control. Personal data, family history, and a record of treatment become a part of the cumulative record of each mental defective identified in the state.

Education.—The trend in the education of mental defectives has been to leave this function largely to the public schools. In South Dakota, the education of mental defectives is a part of the program of social control and is carried on as a coöperative service between the agencies for control and the public schools. There is considerable lag in this phase of the program, but steps are being taken greatly to improve the educational program.

Segregation.—The State School and Home for the Feebleminded provides care for the low-grade defectives in order to relieve their relatives of the burden. It admits patients who are a menace in the community; but as it cannot accommodate a large proportion of the high-grade defectives, the institution does not play an important rôle in the prevention of procreation of the mentally defective.

Sterilization.—This phase of control is the least expensive and most effective means of prevention of procreation. The South Dakota program of selective sterilization is meeting with a growing public approval. It has not as yet affected a large group, as only 304 patients have been sterilized.

Prevention of Marriage.—This method of control is meant to prevent procreation. The method of listing the feebleminded with county clerks who are forbidden to grant them a license is simple. However, vigilance on the part of the state commission is required to prevent nonfeasance in this office. The law can be evaded by marriage in other states. The redress of the state in such instances is to require the patient to be sterilized when he returns to the state.

Supervision.—Supervision is an essential phase in a program of social control of mental defectives who are at large. It is necessary to keep workers in the field to see that these defectives are protected and that the purpose of prevention is made effective.

Social control of the mentally defective has become an accepted social institution in South Dakota. That there has been need for improvement in procedures is manifested by the several revisions in the law. The present laws are not entirely satisfactory. Improvement in method has been made when better ways have become apparent. The eight-phase program seems to be a well-rounded plan for taking care of the mentally defective and bringing about a reduction of their numbers in the future.

BOOK REVIEWS

THE BIOLOGY OF HUMAN CONFLICT—AN ANATOMY OF BEHAVIOR INDIVIDUAL AND SOCIAL. By Trigant Burrow, M.D. New York: The Macmillan Company, 1937. 435 p.

As stated in its Preface, this book is not a theoretical discussion of problems of behavior. It is a summary statement or record of the experimental investigations which the author, together with his associates, has been carrying on over many years. Burrow's position is not one that looks out upon the disorders of human adaptation. Rather he has undertaken an investigation of man *from within*. To this end he has included his own reactions as part of the social reaction-structure, and likewise he gives to the reader, to the reviewer, to the student of behavior generally, the opportunity of reckoning anew with their own internal processes. Thus this book differs in essential respects from the customary treatises that afford only a detached intellectual account of behavior and conflict. "In a study of this sort the student necessarily becomes a participant in a process of adjustment within the sphere of his own bionomic adaptation." So that this essay embodies the attempt "to rally subjective man to an objective appreciation of his own subjective processes."

Burrow develops his topic gradually, as well as his altered approach to it. At the outset he states that "because of the increasing extension throughout the community of a dissociative process that substitutes words for the physiological experience presumed to underlie them, man has increasingly lost touch with the hard-and-fast milieu of actual objects and correspondingly with the biological solidarity of his own organism." There is in our social processes throughout an "unwitting preoccupation with the names of things in place of things themselves," and this ineptitude is a serious handicap in our efforts toward a consistent comprehension of human conflict and behavior disorder. In our accustomed communication and outlook, we take our symbols or language ("pride," "love," "aggression," "dishonesty," "dependence," "acquisitiveness," etc.) for granted and are quite unaware of our total lack of acquaintance with the unexplored reactions that lie back of these abstractions. Our very process of observation is in need of revision. As stated in the Foreword by Mr. Clarence Shields: "The two—the problem and the basis for knowing it—go hand in hand." This "basis for knowing," however, has not yet been established in the field of man's behavior; we have not yet tackled the personal equation and the social preconceptions

which have unavoidably interfered with and distorted all attempts to view objectively the problems of human adaptation. We still assume, somewhat naïvely, that the terms and views traditionally handed down to us in the symbols of language are adequate tools for investigating and handling the biological structures which underlie and motivate man's behavior.

In the present volume the author explains from the beginning that it has been his aim "to question the validity of the normally accepted standards of human behavior." Instead of trying to restore the deviate personality to a conventional social norm, he questions the prevailing evaluations in respect to individual and social health. In what he called "group-analysis" Burrow years ago gave opportunity to students and associates to pursue an experimental inquiry into their own daily living reactions. These studies were undertaken with the purpose of creating an environment of sanity that would not be restricted to "the level of adaptation now accepted everywhere as fitting, desirable, or normal."

Hence this treatise, having to do with investigations carried on for many years under the sponsorship of The Lifwynn Foundation, is based on painstaking socio-biological studies. As stated before, the problem of behavior and the problem of its observation are interrelated. Man's major conflict, according to Burrow's researches, has come about through a specific misapplication of his symbolic capacity —his capacity for forming and using symbols. The organism's feeling has been everywhere deflected into pictorial, self-reverting channels, involving the insoluble self-contradictions that characterize our habitual set of "normal" emotions and that lead only secondarily to insanity and crime. A large part of the present book is devoted to introducing the reader to this totally altered thesis—namely, that the disparity existing in mental disorders and in so-called normality "consists in tensions, alterations, and disturbances which affect definite body-processes." From this basis the theories hitherto current appear, themselves, as but ramifications of this same disturbed condition, the real roots of which tend in a direction that is very different from that which they are commonly assumed to follow. This completely altered frame of reference in relation to the problem of man's behavior is of paramount significance in the understanding of the author's thesis.

While in the first chapters the author takes up the external aspects of man's behavioral inadequacies, his emphasis in the second and third parts of the book is upon those internal modifications which constitute the physiological substrate of conflict and behavior disorder. He speaks specifically of "the discrepancy between those feelings and sensations which belong to the organism as a whole and those sensa-

tions which belong to that circumscribed segment of the organism located in the cephalic region with its secondarily acquired ideas and images." Chapter VI, for instance, introduces quite fully this altered direction of inquiry.

From a phylogenetic standpoint, we may visualize the development of conflict somewhat as follows: In the primitive state of man's evolution the symbol or word occurred in close conjunction with feeling and action. But later the word and its meaning began to take on a more independent position. The symbol served to designate and characterize specific aspects of the environment; thus it became possible to analyze and manipulate the manifestations of the surrounding world. At the same time, however, a misleading situation arose: the fictitious nature of the word or image was often not realized. The original projection of organic sensations into word-pictures gave a spurious reality to the image. Word and gesture gained a magic influence and the period of "animism" arose. Symbols, images, words became invested with an artificial power, capable of dominating the individual's mood and conduct.

Though we no longer express ourselves in the forms of early cults and superstitions, investigations of normal as well as neurotic processes show that we are still in this period of magic interaction. The human organism, having lost its immediate touch with the environment, tries to compensate for its own insecurity by finding interest and activation in a system of images and beliefs, wishes, phantasies, opinions, which bear but a secondary (symbolic) relation to man and his basic position in the universe. Man thus strengthens the alliance between image and feeling and he reënforces the power that overtly the symbol has come to assume over his organismic processes. The organism has placed itself under the domination of the accidental and ever-changing stimuli of socially conditioned images, words, and gestures. In this adjustment not only have the symbol-reality and its actualizations in social custom and interchange in large measure lost touch with man's primary needs, but there is in this process a displacement, a de-centering of interest and motivation that entails an essentially unstable adaptation. This results not only in a lack of poise, of spontaneity and self-determination; it entails an internal conflict between organismic action-patterns—between neuromuscular patterns that belong to the organism's total function, and patterns that are concomitant with the symbolic sphere and its socially conditioned competitive action-units. It is toward this internal biological conflict or imbalance extending throughout the race that Burrow's investigations are directed. They are directed toward assisting a developmental step that involves the withdrawal of the emotional processes from their complicity with the symbol as it is socially sys-

tematized in the "pseudo-self" or "I." His effort is toward an organismic re-centering of tensions that will establish a condition of balance in which the organism's "central constant" is dominant, while it uses its symbolic tools merely for its objective adaptation to the environment—a balanced condition in which the organism is not dominated by symbols or external stimuli, but in which it preserves its mastery of the total situation.

In order to understand the broader program of research and reorientation represented in this book, it is well to keep in mind certain principles which the author long ago emphasized in his earlier writings. As early as 1914 Burrow spoke of the social aspect of behavior disorders. In his work as a psychoanalyst he pointed out the defense mechanisms, the infantile makeshifts and illusions which are commonly regarded as social custom rather than as pathology. We find throughout his investigations and publications a consistent analytic challenge of the prevailing social mood, of a social systematization within which the individual is an interwoven element. He speaks of "an ill-concealed social neurosis" (1925) that is active everywhere—in ourselves, in our immediate social group, and in society generally. A system of "social images" (1923) is at work throughout the social consciousness which forces the individual to be occupied almost entirely with his own image and its reflections. He is dependent in his feeling and action upon socially corroborated ideas of success, reputation, class distinction, religious adherences, economic rights, sexual possession, and so forth—all of them variations of the parent-image that have become crystallized in the self-image of the individual. In his *Social Basis of Consciousness* (1927) Burrow discussed the prevalence of a social dream state in which each individual is matched against every other, clinging to his fancied privilege and rightness, obedient to accidental gestures and stimuli that are engendered on all sides through his quest for parental approval. Even so long ago the author insisted that we cannot arrive at a thorough understanding and handling of neurotic behavior as long as we do not envisage in our investigation the structure of this social neurosis and *our own inclusion in it.* This inadequacy expresses itself not only in neurotic difficulties, but also in such destructive disorders as crime, economic and national warfare, in obsessive personal competitiveness, and in the social dissensions that everywhere impede the welfare of the race and the growth of native human values.

Burrow's consistent emphasis upon the social nature of behavior disorders has clearly left its mark upon the thought and outlook of other investigators, who, however, in discussing their socio-psychiatric

viewpoint too often fail to acknowledge this early influence and its source. It is quite true that what is usually referred to by psychiatrists as social influences and causations in no way covers the phenomena pointed out by Burrow. He goes much beyond the conventional viewpoint when he questions normal behavior reactions throughout, including those that make up the observer's own daily responses. Such a basic inquiry is very different from the effort to spot especially unfavorable social factors in the environment of a specific patient. The average student of behavior, being trained to focus on the outer item and to disregard the larger setting, naturally feels a "resistance" toward a procedure that attempts to investigate the underlying structure. But subterfuge and disguise, evasion and competitive defense are viewed by Burrow in normal as well as in neurotic behavior, and in both they are referred to an internal biological conflict that is racial. Our superficial psychiatric palliatives will no longer suffice. It is necessary that the observer include his own processes as part of a socially conditioned structure. This problem cannot be sidestepped through an emphasis on symptomatological differences or by a merely intellectually perfunctory inclusion of oneself. As I know from my own experience as a participant in Dr. Burrow's phylopathological researches, the inclusion of one's self is a most difficult and elusive task. Perhaps the chief difficulty is the circumstance that this self-inclusion does not as yet enjoy public support. The premium everywhere is still upon external appearance, upon good conduct and social approval. This automatic defense of the flattering self-image unavoidably contradicts a more sober inclusion of one's own behavior discrepancies.

From the background of these considerations it will become evident, I believe, that the research undertaken in Burrow's group- or phylo-analytic set-up is wholly different from certain group-therapeutic procedures recently described by a number of psychiatrists. In these latter efforts the psychiatrist remains supreme; he does not really include himself as an intermeshed and active element within the social and racial situation with which he is confronted. And in this artificial aloofness he can only maintain a moralistic, preceptive attitude that bars the possibility of a more basic research.

Burrow's researches, as presented in his *Human Conflict,* take account, then, not only of neurotic and psychiatric manifestations, but also of the instances of anxiety, aggressiveness, self-contradiction, image-worship, and so forth that belong to the reaction-sphere of normality. According to his findings we are forced to include in the scope of our inquiry the internal disorganization that underlies man's social symptoms, his economic, industrial, and political

conflicts. At the same time we find the focal point of these disorders in the biological reaction-pattern which each observer carries within himself in his own internal disorganization. As the author repeatedly emphasizes, we cannot expect to cope with these problems by altering the accidental and external features of them. Moralistic prescriptions, wishful programs, hope for better conduct cannot meet the deeper underlying need. Adjusting the patient to normality as the psychiatrist—the symbolic "I"-persona—sees it does not fill the bill. It is one of man's developmental *faux pas* that for immediate practical purposes we have had thus far to be satisfied with attaining a "normal" adjustment. So that the task before us is to question and understand this normal configuration *both in me and in you,* as a general form of adaptation in all its thousand cultural forms and facets.

For the serious investigator, the conflict in human behavior cannot remain a matter of speculation. It is his task to discriminate in himself, in his own neuromuscular action patterns, between the organism's primary total configuration and the "partitive," symbolic, socially conditioned pattern. The realization, internally, of the basic organismic pattern gives him a foothold, as it were, a basis from which he may proceed to investigate and adjust his own conflict and that of his patient. Without this biological and phyletic basis, the task—as has been too generally proven—is impossible; it means the attempt to lift one's self by one's own bootstraps. But in taking up the experimentation with tensional patterns as they relate to man's different modes of functioning organismically, the investigator finds himself upon objective bedrock; he has reached a level of observation and procedure which, contrary to the procedures thus far applied to behavior disorders, is not any longer caught up in the socially conditioned self-image.

It may be appropriate to mention here that Dr. Burrow himself is well aware of the difficulties of language as a medium for presenting his researches. As far as possible he has used the terminology long established in scientific literature, but at times he has been compelled to employ these familiar terms in a somewhat unusual sense. In referring to material that was of special significance in his work he was obliged to create a number of new words such as "phylopathology," "cotentive," "partitive," "intrinsic and extrinsic constant," and the like. This altered usage is explained in a carefully prepared glossary, but the author himself also states that his "present terminology represents perhaps but a transitional phase in the development of the principles subsumed under the term *phylobiology.*"

What is important for the reader is to realize that many of our

socially current definitions touching human behavior, as implied in the common terms of our language, are not accepted by the author. His altered terminology is an expression of the reorientation that is developed throughout the book and is intended to assist the reader in his own reorientation. Our all-too-easy use of familiar terms readily beguiles us into viewing things familiarly. But Burrow's position is essentially a challenge of accustomed concepts and values. This aspect of his thesis cannot be too strongly stressed.

As an interesting aspect of behavior, it may be mentioned that readers and reviewers not infrequently make use of any difficulty they may find in an author's special vocabulary or manner of formulation to support criticisms that spring from an emotional bias. This tendency is a handy shield against the admission of rigidity within one's self. In accordance with the superficial, verbal type of adaptation that marks our present-day civilization, there is much difficulty in returning—in matters of behavior and behavior research—to the essentials, to the underlying structures. Or we may find readers and reviewers misrepresenting an author's position by overlooking significant aspects of it. In the case of the present book, reference to the glossary would be the natural recourse were criticism based on an objective interest in the problem. It is precisely such distorted interpretations as are due to emotional, or to self-defensive and competitive motivation, that Burrow would include as part of a social reaction trend which is in need of investigation.

From the organismic or phylobiological position adopted by Burrow and his associates, a basis has been established from which the processes of our normal interchange may be viewed afresh. The total organic pattern constitutes a background from which the limited partitive pattern with its socially conditioned behavior may be observed and adjusted. A new field of research opens itself which demands a specific technique and which cannot be absorbed into the terms of current schools of procedure. The attempt to visualize or formulate this altered outlook in the concepts of the now existing approaches must unavoidably lead to disappointment. The situations referred to in such terms as libido, the three divisions of the ego, inferiority complex, collective unconscious, and so forth rest upon a wholly different, imaginal frame of reference. They fail to demarcate between biological principles and rationalistic self-conscious inferences. They do not take into account the observer's own bias, they overlook important aspects of the pathological reaction when they fail to include in their observations the unhealthy imposition of the normal environment against which a patient's neurosis may represent a revolt. In general, they do not delineate

a "central constant" that would serve as a measure of discrimination and attainment.

From a phylobiological basis, then, psychiatry has a new and broadened function before it. It will be interested in the mental health, not only of the individual, but of the race. Mental hygiene cannot be satisfied with patching up here and there, but must turn its attack to more fundamental issues. It must make use of tools that are commensurate with the larger scope of its task and direct its research consistently toward behavior disorders in all their social forms and biological involvements.

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SOCIAL TREATMENT IN PROBATION AND DELINQUENCY. By Pauline V. Young, with Forewords by Roscoe Pound and Justin Miller. New York: McGraw-Hill Book Company, 1937. 622 p.

The twenty-seven chapters of this book are grouped under four headings.

Part I, *The Approach to Individualization of Justice,* attempts, through the presentation of detailed case studies, to show how varied, intricate, and individualized are the myriad forces and "causes" that lie behind (and indeed produce) an apparently simple delinquent act. Part II, *Legal Aspects of Probation,* documents carefully the origin of the juvenile court, its present status, the theory back of its operation, its methods of examination, and its procedure. Part III, *Dynamics of Social Therapy in the Work with Unadjusted Youth and Parents,* similarly lists a very large number of problems which force themselves upon any court worker. None is given much discussion, but there is enough to indicate how hopelessly ramified are the roots of each. Part IV, *Utilization of Community Resources in the Work of Unadjusted Youth and Parents,* calls the reader's attention to the value of using the church, the school, and the sources of recreation. It contains a good picture of the coördinating-council movement.

The volume is the result of what must have been an enormously painstaking piece of work. Indeed if one were to take from its pages all the lengthy case histories gathered from various agencies and all the quotations from various authorities, there would be very little left. For the beginner, it is an adequate photograph of the mechanics of court procedure, of the multitude of social factors that lie back of maladjustment, and of the agencies that can be turned to for help in treatment. For the more experienced, it is a good indicator of where to go for further information on some particular point in the field.

It is a distinct service to bring together so much data and so many documents in so ordered a way. Yet, we venture, this is not our most acute need to-day. Information abounds. Thousands of weary workers, for thousands of weary hours, have been putting data into case histories. These data have been swept up already in a good many weary books.

We need an ordinate and abscissa to which this multitude of dots can be referred. Points in an area have reality in themselves, but they have no reality in relationship to each other until the setting up of lines of reference permits the construction of a formula that gives definition to these relationships.

To change the metaphor, the present book is an excellent photograph, but we need a painter, not a camera man.

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STEP BY STEP IN THE NURSERY SCHOOL. By Jennie N. Haxton and Edith Wilcox. Garden City, New York: Doubleday, Doran, and Company, 1936. 224 p.

Many books have been written describing the behavior problems of young children and analyzing the probable causes of these difficulties, but workers are rarely willing or able to present a clear picture of their treatment methods or of the various concrete steps involved in helping a child to achieve a more successful adjustment. The value of this little book lies in the fact that the authors not only describe the behavior problems presented in selected cases, but also describe in considerable detail the exact treatment measures applied during the hours when the child was in the nursery school, and the results that were achieved in the way of modifying the undesirable behavior trends.

The problems treated included temper tantrums, domination, slapping, eating difficulties, wetting, retardation in walking, undesirable reactions to touching and possessing, and insecurity and fear. These problems occurred among about thirty children, ranging in age from twenty months to two and one-half years of age, who were attending a nursery school maintained by the New York Kindergarten Association, on whose staff Miss Haxton is a supervisor and Miss Wilcox a principal of one of the thirteen nursery schools and day nurseries conducted by the organization.

It is evident that the principal of the nursery school was sensitively aware of the behavior problems among the children and of their implications for future adjustment. She seems to have been an unusually keen observer, resourceful in treatment and careful in

recording the details of behavior and treatment. The treatment consisted of simple habit training consistently applied with kindly objectivity, firmness, and great persistence. The child gradually learned, through direct and repeated simple life experiences, more desirable ways of behaving which increased his freedom and happiness in the life of the group.

The book is written in a clear, interesting style and is attractively illustrated with eight photographs of the children studied engaged in the absorbing activities of the nursery school. The book should be of interest to workers in charge of the training of young children in day nurseries, nursery schools, and other similar agencies and institutions, and to mothers who are interested in habit-training methods.

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LEARNING TO BE GOOD PARENTS; TALKS TO FATHERS AND MOTHERS. By Eleanor Saltzman. Boston: Manthorne and Burack, 1937. 55 p.

In fifty pages divided into fifteen "talks," Miss Saltzman tells parents swiftly and simply a colossal number of facts. She explains the necessity felt to-day for research into child development; gives the "do's" and the "don'ts" deduced from current theories as to physical, mental, and emotional growth; and discusses diet, eating and sleeping habits, play, toilet training, personal relationships, sex, and children's diseases.

Implicit in some of the talks is the assumption that many of the author's audience are simple folk of limited financial means and probably limited education. The style is that in which well-trained raconteurs tell stories to children of from four to six years of age. One might, therefore, wonder whether Miss Saltzman regards limited education as synonymous with limited native intelligence were it not for the tremendous number of ideas she presents to be understood, amplified, assimilated, and put into practice by those who, through reading the pamphlet, are "learning to be good parents."

To be happy parents is a definite recommendation for being good parents, but it is left entirely to the parents to discover how to be happy. Other cognizance of parental emotion appears in the repeated warnings not to be impatient and not to be ashamed of sex.

In Talk Number 13—*Jackie and Jane Play*—there are some specific and practical suggestions for acquiring adequate play equipment inexpensively.

In Talk Number 14—*Telling Jane About Babies*—an illustration is given and the proper names of organs are supplied for the parent

who lacks a scientific vocabulary. But the author apparently does not speculate as to whether a parent can follow the advice to be at ease in discussing reproduction with her three-year-old daughter while employing an unfamiliar terminology.

The reviewer, however, speculates as to how readily a parent can learn to be a good one from a perusal of this closely compacted collection of data and injunctions.

The booklet would be more useful to leaders of parent-education study groups, providing, as it does, a ready-made outline of topics and questions in which parents are interested. Each of the fifteen talks contains enough material to stimulate an hour or more of discussion among parents.

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PERSONALITY STUDIES OF SIX-YEAR-OLD CHILDREN IN CLASSROOM SITUATIONS. By Alberta Munkres. (Contributions to Education, No. 681.) New York: Teachers College, Columbia University, 1936. 181 p.

In an attempt to devise a method for the study of personality patterns in young children that the ordinary classroom teacher with little or no training in formal methods of research may use and find helpful, the author observed each of ten six-year-old children for a total of 80 five-minute periods in the classroom situation and made detailed records of his general behavior and social reactions according to a general plan that had been worked out in a series of preliminary trials of the method.

Clear-cut differences between the children were apparent in the descriptive records, which are given in very complete detail in the body of the monograph. The author concludes that the method is a valuable one because it is applicable to many situations and can be used by persons of little training. It is, therefore, especially suited for teachers in training, who are usually required to do a good deal of classroom observation before beginning their periods of practice teaching. She points out, however, that it has limited usefulness for research purposes and is very time-consuming as compared with other methods in common use.

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THE MAN TAKES A WIFE. By Ira S. Wile, M.D. New York: Greenberg, Publisher, 1937. 277 p.

The 1930's have seen an increasing preoccupation with the vital subject of marital adjustments, as reflected in the rise of clinics and institutes for marriage counseling, public conferences and college

courses on family relations, and the orientation of social and mental-hygiene programs to education for family life, to say nothing of the spread of maladjustments mirrored by climbing divorce statistics and the increasing activity of domestic-relations courts.

Dr. Wile's latest book is a timely contribution to the extensive literature growing out of these developments, all the more valuable coming, as it does, from the pen of a physician versed in the psychological and psychiatric meanings and issues involved in any basic consideration of these matters.

Its purposes, as Dr. Wile defines them, are to present a synthesis of the practical phases of male living in America and England; to picture the general life of a man in relation to his wife and children; to center attention upon the normal, rather than the pathological, with special reference to the "masculine life cycle"; "to enable men to understand themselves better"; and to serve "as a guide to women in their endeavor to solve such problems as depend upon an appreciation of the nature of the male."

These purposes the book well succeeds in fulfilling. It is packed with useful information, practical insights, and homely wisdom, buttressed by the technical knowledge of modern psychiatry, presented simply, readably, and, in spots, eloquently, inspiringly, and humorously. Its exposition of the strengths and weaknesses of the male, his egotisms and foibles, his nobilities and less lovable qualities, and its deflation of the traditional conception of man as "lord of the manor," recall, in their less serious aspects, shrewd observations of the Sunday-supplement cartoonist who entertained us with *Bringing Up Father* and its gentle lampoonings of the masculine sex.

On the debit side, as some will see it, is the author's diluted concept of marriage as a social institution and his liberal stand on divorce and certain aspects of sex, which those with the traditional Christian philosophy of wedlock will be unable to accept. The values posited in his view of matrimony, so characteristic of the modern outlook with its subordination of moral motivations in the religious sense, are, they will say, frail reeds for the stabilization and support of this ancient, but at present shaky institution. Incidentally, they will point out that the cures for marital ills prescribed in Dr. Wile's penetrating study rest on goals and behaviors that are in the last analysis moral and religious in their fundamental connotations.

But these considerations aside, it is a wealth of knowledge, practical information, sound advice, and common and uncommon sense, as well as good mental hygiene, that Dr. Wile offers us in his facile and engaging manner, and all of us, whatever our deeper persuasions, can live by and profit from it. It is a temptation to quote from his

sapient observations and the many bits of wit and wisdom, aphorisms and epigrams that pervade his pages, but space forbids.

PAUL O. KOMORA.

The National Committee for Mental Hygiene.

THE SHORT CONTACT IN SOCIAL CASE-WORK; A STUDY OF TREATMENT IN TIME-LIMITED RELATIONSHIPS IN SOCIAL WORK. By Robert S. Wilson. New York: National Association for Travelers Aid and Transient Service, 1937. 2 vols., 201 and 219 p.

In these two compact volumes, covering respectively theory and cases, Dr. Wilson has given us clear, readable, and stimulating material. With the short-contact interview as a basis, he goes back over more general case-work philosophies and practice, analyzes objectives and techniques, and suggests their historical development. Relationship, treatment, and diagnosis are presented with a feeling for the dynamic quality of each. Their use, their differences, and the activity that goes into the whole and the parts are recognized and discussed. In reading one gets a great feeling of the practical utility of these concepts which we have all worked over and which in their theoretical presentation too often have been made to seem obscure and heavy.

In the volume on theory, two chapters define the short-contact interview and deal with the "philosophy and technique in time-limited relationships." These are a prelude to the chapters on the Travelers Aid and Transient Service and on the short contact in the public relief agency.

Perhaps the most provocative concept developed in the book is that of the "time-limited relationship" in case-work. This dynamic phrase throws new light on an old subject and opens the way for an examination of the differences that define a brief contact with another person. A relationship is set up and something happens because of this. The immediacy of this quality of relationship, the free use by the case-worker of his particularized skills within a limited time, the readiness to recognize the client's immediate objective while other facets of his plan are constantly within the vision of the case-worker, the business of what is happening to both client and case-worker are reanalyzed in a refreshing way. The Rankians have given us the theory of the conscious use of time by both client and case-worker in a treatment relationship. In part of Dr. Wilson's discussion, we find a recognition of certain unquestionable values for case-work in this theory and a consideration of what can take place in a relationship where time is in reality limited.

The volume of cases gives us a rich sampling of the material on which the theoretical discussion is based. The cases are grouped under four headings: ***Treatment Plan Completed in a Time-Limited***

Contact, Short Contacts Preliminary to Transfer to Another Agency, Short-Time Treatment Relationships Within Extended-Care Cases, and *Desk Rejects From a Public Agency.* We are swept here into material that gives us pause for thought. This is not the place to discuss what treatment is, but certainly we would all agree that time is a factor in it. We see here situations that are handled on a treatment basis—one aspect of treatment being an understanding of the psychological meaning of the other person's behavior. This understanding is reached and utilized by the case-worker in her first interviews with the client largely because the limitation of time makes this essential.

We may have gone along very comfortably with Dr. Wilson in his presentation of theory. The case material is bound to give us a new understanding of the demands on the case-worker in a time-limited relationship. The crisis of the client becomes something more integrated with his life experience. His strangeness and isolation in a new community ask for direction from the social worker. The skilled case-worker is guided in her activity, no matter how immediate this must be, by an awareness of the many facets of the client's situation. Limited time is used as an asset rather than as an obstruction, and the client's feeling of urgency is met and handled with him.

Here are given as complex situations as come to any of us for longer periods of treatment, and our most insistent question undoubtedly will be, "Were the results lasting?" The suicidal girl, the marital problem of the young married woman, the boy who hates his stepfather, but cannot complete his plan to run away—these are some of the problems that may have their first expression to the social worker in a crowded railway station. The handling of these situations must make us all examine them thoughtfully and perhaps formulate more clearly our ideas as to when a treatment relationship may be said to begin. The grouping of cases is fortunate, since it gives us examples from some of the most difficult and most discussed areas of case-work. Although the majority of cases are from the Travelers Aid or transient field, one case (No. 9, Section II) in particular is a nice example of a consciously chosen short-time relationship. In one or two of the cases presented we would feel that there is good teaching material.

Dr. Wilson has given us two important volumes, which among other things help us to realize how far case-work has gone in the last ten years in its effort to understand individual behavior. His thesis both extends old concepts and expresses new ones in a way that must make us reëstimate our thinking and practice.

ELEANOR BARNES.

Charity Organization Society, New York City.

PROCEEDINGS OF THE SECOND NATIONAL CONFERENCE ON COLLEGE HYGIENE. New York: The National Tuberculosis Association, 1937. 112 p.

This book is a report of the proceedings of the Second National Conference on College Hygiene, held in Washington, D. C., December 1936, under the sponsorship of the President's Committee of Fifty on College Hygiene, The National Health Council, and the American Student Health Association. In it the conference sets forth what it conceives to be the legal, social, and educational responsibilities of schools, colleges, and universities toward the health of their students, together with details as to how these responsibilities can best be met. Emphasizing health as a state not limited merely to an absence of illness, but as a condition of well-being that embraces physical, mental, and emotional hygiene, the conference sets forth the standards of organization, procedure, equipment, and personnel required to maintain student health on this positive plane.

Of special interest to all governing boards should be the section devoted to mental hygiene. In it the conference emphasizes that the mental aspect of student health is of just as vital moment as the physical, and equally in need of special and appropriate attention. Realizing that educational institutions need guidance in meeting this need, the conference sets up and discusses in detail the standards for a college mental-hygiene program. They are to be complimented for giving special attention and thought to this aspect of the college health program.

The report is useful as a measuring rod for the ever-growing responsibilities of every educational institution in the matter of the protection, maintenance, and promotion of the health of its students. The reviewer recommends that this report be seriously consulted by every one whose work is concerned with these responsibilities.

WALTER C. WEIGNER.

Butler Hospital, Providence, R. I.

TWENTY-FIVE YEARS OF HEALTH PROGRESS. By Louis I. Dublin and Alfred J. Lotka. New York: Metropolitan Life Insurance Company, 1937. 611 p.

From the viewpoint of political history, social welfare, and economic well-being, the past twenty-five years did not fulfil reasonable expectations. During this period the world's worst war was fought and in many civilized countries autocracy replaced democracy, tyranny abolished freedom, and poverty succeeded plenty. In 1911, mankind was confidently looking forward to a glorious future in which peace and plenty would abound. The vision soon passed away and has not yet returned. In view of these distressing develop-

ments and disappointments, it becomes highly gratifying to read such a thrilling story of health progress as Drs. Dublin and Lotka have given us. In the health field the scientist has been allowed to lead the way, and the discoveries made in scientific laboratories have been adapted for use in safeguarding and promoting the health of people of all classes. Naturally, beneficial results appear in more abundant life, in less disease, and in fewer deaths.

The book deals principally with the mortality experience of the industrial policy-holders of the Metropolitan Life Insurance Company during the quarter century from 1911 to 1935. This experience is compared with that of the people of the whole country as evidenced by the vital statistics compiled by the Federal Census Bureau. At the outset it is pointed out that the period covered has been one of great health progress. Many serious diseases have been brought under control and the ravages of others have been lessened. Health departments have been strengthened, and health work consequently has been made more efficient. The people generally have learned the principles of hygiene and have actively participated in the movement for the prevention of disease and the upbuilding of health.

To show definitely what has been accomplished during these twenty-five years, the authors present data covering three different periods—one extending from 1911 to 1915, one from 1931 to 1935, and one covering the whole time from 1911 to 1935. Gains are shown by comparing the results of the first five years with the results of the last five years. Death rates by age groups for white and colored persons separately are shown for each of the periods. In the white population the death rate was reduced during the twenty-five-year period by over 38 per cent and in the colored population by about 30 per cent. Gains in reduction of death rates were found for each age group. The largest gain, as would be expected, is for the years from one to four; the next largest gain among white males is for the age group from twenty-five to thirty-four years, and among females for the age group from five to nine years.

Comparing death rates among males and females, the authors find in the white population higher rates among males for every age group. In the colored population during the entire period the death rates in the age groups from fifteen to twenty-four years were higher among women than among men. The trend of mortality during the period was downward, with the exception of the years 1918 and 1919 when the serious influenza epidemic was experienced.

Even more striking than the reduction of death rates was the gain made in expectation of life during the twenty-five-year period. In the years 1911–1912, the expectation of life of the insured persons in the industrial department of the Metropolitan Life Insurance

Company was 46.63 years; in 1935, it was 60.25, a gain of 13.62 years. During the same period the gain in expectation of life in the registration area in the United States was 8.35 years.

The authors make a thoroughgoing analysis of death rates from the principal diseases and point out the protective measures that have produced such wonderful results in the control of tuberculosis, diphtheria, typhoid fever, and other communicable diseases. They also discuss the progress made in combating cancer, heart disease, and arteriosclerosis. These diseases of old age are not so susceptible to the influence of preventive measures, but they have been brought under partial control. Great gain is recorded in the treatment of external cancers and other forms of cancer that can be observed by the physician. Heart disease now ranks first among the diseases that cause death. Tuberculosis, which ranked first in 1911, was in fifth place in 1935. From 1921 to 1929 the trend in the death rate from heart disease was upward, but since 1929 the trend has been downward. It is pointed out, however, that the apparent gain may be partly due to changes in reporting.

The authors state that it is estimated that 7,000,000 persons in the United States have syphilis at a given time, and that one of ten adults will be affected by the disease at some period of life. They point out that the trend in the reported death rate from syphilis is downward, but that the ravages of the disease are not fully known.

An impressive chapter of the book deals with automobile accidents. The mounting toll of deaths from this cause is appalling. Fortunately the death rate from other accidents is declining.

The book as a whole is a remarkable review of achievements in the health field during the past quarter century. It merits careful study by every one interested in human welfare.

HORATIO M. POLLOCK.

New York State Department of Mental Hygiene,
Albany, N. Y.

A PURITAN OUTPOST; A HISTORY OF THE TOWN AND PEOPLE OF NORTHFIELD, MASSACHUSETTS. By Herbert C. Parsons. New York: The Macmillan Company, 1937. 546 p.

Herbert C. Parsons has for years been actively and vitally interested in the mental-hygiene movement. He served for twenty-five years as a trustee of the Wrentham State School, was for some time a member of The National Committee for Mental Hygiene, and is now on the executive committee of the Massachusetts Society for Mental Hygiene, of which he was president for several years. It is not surprising, therefore, to find that he has not omitted con-

sideration of the problem of mental defect and disorder in this splendid history of his native town.

A leading member of the Northfield community, Dr. Edward Jarvis, Harvard Medical School, 1830, active in the public, literary, and social affairs of the town, and a popular lecturer on natural history, was a pioneer in the state care of the insane and in the movement for state registration of vital statistics. As a member of the State Commission on Lunacy, he wrote the "Report on Insanity and Idiocy" in Massachusetts in 1855, urging a greater humanity in the care of the feebleminded and psychotic, and a wider degree of state interest in their care. Northfield, in common with other towns, resented somewhat the intrusion of state interest "in matters that had always been home concern."

> "Dr. Jarvis made out a great case for better care of the insane than keeping them in dark dungeons; but Northfield did nothing like that. He had counted all the lunatics in the state—and it was cheering that he found only two in Northfield, while smaller towns like Montague, Shutesbury, and Whately had six each, while Deerfield actually had ten. When it came to idiots, the town scored higher, with four males and one female, while most of the towns had only two, one, or none. Perhaps idiots were more clearly recognized in Northfield, by virtue of contrast to average intelligence; and it was something that four of the five were 'independent' against one who was a pauper. Even a fool in Northfield could be independent. Thus some comfort was gained by reading Dr. Jarvis' learned report."

As may be gathered from this one extract, this history of Northfield is no ordinary town chronicle. Mr. Parsons has emphasized the basic social and economic problems, and the national implications of local town activities. The breadth of the book encompasses the development of other early New England settlements.

Where other histories emphasize wars and important dates, this book tells how the people lived through the wars and between the notable occurrences. It is a studied and delightful treatment of a town off the beaten track of our large cities, which has not been without its figures of importance. In essence, it reflects the wide interests of the author's long and progressive life.

Concluding with a biographical section on important Northfield men, the book is easily entered by means of a very thorough index. Once it has been entered, at any point, the temptation is irresistible to enjoy the whole of it.

BENEDICT S. ALPER.

Massachusetts Child Council, Boston.

APPLIED DIETETICS. By Frances Stern. Baltimore: Williams and Wilkins Company, 1937. 263 p.

To any one, particularly a physician, who is interested in mental hygiene, Miss Stern's book is indeed welcome. It is about the most practical treatise one could have in this field, since it is not only immediately helpful in the prescribing of diets, but it is imbued with the social-work and psychiatric points of view.

In a volume on this subject one ordinarily expects to find tables and text given over almost exclusively to physical-chemical concepts, as many authorities in this field tend to treat the individual at this level. But for Miss Stern the individual for whom a diet is prescribed is a feeling individual, with a personality and experiences unique to him. There is a special section of the book on the interrelationship of food and mental attitudes which is of particular significance from the mental-hygiene standpoint, but in addition to this a large part of the text is permeated with material that emphasizes mental and personality factors.

Part I deals with such topics as the daily food requirements of the body; the construction of a normal and a therapeutic diet; the environmental factors that influence the effectiveness of the diet; and the education of the patient. The two chapters on this last topic are particularly valuable, as they give considerable detail in regard to the approach to the patient. This is of great importance because the effectiveness of a diet often depends on how a patient is instructed in its use and in its personal significance to him and his particular condition.

Parts II, III, and IV are more technical in nature, giving tables for the computation of the diet, dietary outlines, and typical diets and menus.

HENRY B. ELKIND.

Massachusetts Society for Mental Hygiene, Boston.

FINDING YOURSELF IN YOUR WORK: A GUIDE FOR CAREER AND PERSONALITY. By Harry Walker Hepner. New York: D. Appleton-Century Company, 1937. 297 p.

The author of this interesting book has undertaken the thankless task of translating mental hygiene into language that can be understood by the layman who wants to make use of its principles in choosing an occupation and adjusting himself to it. Readers whose primary concern is the advancement of the profession will be distressed, as they inevitably must be by any document which relinquishes scientific restraint in the interest of lay readers. Others will commend the book as a significant initial attempt to apply the principles of mental hygiene to vocational adjustment.

In recent years many readers have recognized the controlling

influence that mental attitude frequently exercises over the adjustment of the worker, but no one has undertaken to explain all this to the worker himself. Professor Hepner has tackled the job. Whether history will place him beside King Arthur or Don Quixote remains to be seen.

The result is a book which the honest reviewer ought neither to endorse nor to condemn, for those who depend upon the review will inevitably disagree among themselves when they read the book. This much may be said with assurance—no one interested in vocational counseling can afford to pass it by without careful examination.

ROBERT HOPPOCK.

National Vocational Guidance Association,
New York City.

SCHOOL HEALTH PROBLEMS. By Laurence B. Chenoweth, M.D., Theodore E. Selkirk, M.D., and Richard Arthur Bolt, M.D. New York: F. S. Crofts and Company, 1937. 387 p.

School health examinations are practically routine procedures in modern educational systems. With the advance of knowledge in the medical and psychological sciences, school hygiene has made rapid progress. The facts warrant the practical application of all known theories in the field of constructive school service. The oft-quoted statement of President Hoover—that approximately 10,000,000 public-school children vary from what might be regarded as normal standards—is indicative of the seriousness of the problems involved. The purpose of the authors of the volume under review is too stimulate students and to facilitate the education of teachers so that they may appreciate the extent of their opportunities for improving the physical and mental status of school children.

Without special attention to the technics, familiarity with which is assumed, the authors provide an excellent outline of sound practice. Their presentation is couched in simple terms, and the contents are adapted to the teacher-student public for which the book was written. Each chapter is supplemented by well-selected references, facilitating further study. The subject matter deals with problems of growth and nutrition, the nature and goals of physical examination, the control of communicable diseases, and the hygiene of light and vision, acoustics and hearing. There are excellent chapters on special classes for handicapped children and on tuberculosis in the schools. The book concludes with an outline of school health administration, followed by a brief and satisfactory glossary.

One chapter of thirty-five pages, approximately one-tenth of the book, is devoted to mental hygiene. The presentation is brief, but with well-diversified emphases. Its aim is to be provocative rather

than definitive. It offers an adequate exposition of the nature and meaning of child-guidance clinics and stresses the "desperate" need of them in public schools, not merely in the interest of the children directly concerned, but for the sake of advancing the education of the teacher in a field that concerns the well-being of all pupils.

But although mental hygiene is recognized as an adjunct to the development of mental processes and as such is discussed along broad lines, there is, unfortunately, insufficient correlation of the mental-hygiene material with the rest of the subject matter. When all is said and done, the body-mind unity is such that all comments upon teaching and learning that relate to the control of contagious diseases and to malnutrition are definitely related to the mental well-being of school children.

Despite this lack of correlation, however, the volume is one that should be distinctly helpful, particularly to rural school-teachers, directors of physical education, students of public health, and medical examiners of school children. IRA S. WILE.

New York City.

APES, MEN, AND MORONS. By Earnest A. Hooton. New York: G. P. Putnam's Sons, 1937. 304 p.

A distinguished Harvard professor of anthropology is impatient with attempts to cure malignant biological growths by using "patent sociological nostrums. The emergency demands a surgical operation."

"Fools cannot be transmitted into sages, criminals into saints, and politicians into statesmen. Surely this conception is nothing but a secularized belief in conversion and personal salvation. The clergyman of yesterday is the unfrocked sociologist of to-day. When are we to realize that a great proportion of mankind continues to be as stupid, unteachable, bloodthirsty, predatory, and savage as we are wont to imagine that maligned and regrettably extinct precursor—Neanderthal man?"

"No little of the human germ plasm is poisonous slime, and we have not had the intelligence and the courage to attempt to find out anything about human heredity. We have imagined universal education, mutual understanding, and improvement of the social environment to be the ingredients with which we can concoct the human millennium; we have mixed them up and stirred them in, and turned out a horrible mess. There must be something the matter with our basic element—man himself. . . . In medical science lies the only practicable control of human evolution and of biological progress. Medical science must cease to regard its function as primarily curative and preventive. It must rid itself of the obsession that its chief responsibility is to the individual rather than to society. It must

allocate to itself the function of discovering how the human animal may be improved as a biological organism. The future of mankind does not depend upon political or economic theory, nor yet upon measures of social amelioration, but upon the production of better minds in sounder bodies." (pp. 269, 270.)

With much of the above all thoughtful persons will agree, especially when it is put with the force and the wit of these essays and occasional lectures. Dr. Hooton's field is physical anthropology. He deplores the fact that man knows relatively little of his animal origins and resents them. He himself offers many interesting pages on the process whereby cultureless brutes probably hoisted themselves on their hind legs and achieved so-called humanity.

His zeal for eugenics does not mislead him into the absurd racial theories of the Nazis. "In Germany the obsession of race has grown from a morbid inferiority complex to a national psychosis" (p. 145). "No pure race can be found in any civilized country" (p. 153). The unfit whom he would keep from breeding are the unfit in every ethnic stock, nation, or social group whatever. He realizes further that sterilization would not of itself improve the breed of the fit, but only give them a better society in which to exercise their powers. And though he is more hereditarian than environmentalist, he insists that hereditary endowment needs the encouragement of environment to develop its full potentialities.

Unfortunately he gives the impression of regarding democracy as nothing more than "making the world safe for morons." His own many paragraphs on the absurdities of dictatorship might have kept him from so (unwittingly) playing the game of the Nietzcheans. His diatribes against progressive education are also below the level of the rest of his book. Modern schools do not attempt to abolish hard work; they do not regard proficiency in arithmetic and spelling as negligible; they do not treat inferior types like better ones nor seek to educate the masses beyond their capacity. They try—with the patience needed in every sound attempt to increase our knowledge of human beings—to find ways whereby children will do hard work willingly and so more lastingly. Tests show that when children see the sense in arithmetic and spelling, they master these skills better than in older days. If any people have been trying to discover where children differ and to develop to the utmost the valuable differences, it is these progressive educators whom Dr. Hooton, by focusing attention on the errors of some users of that name, has caricatured rather than described. When a book as needed as this is goes into another edition, it is to be hoped that the author will delete these divagations from his scholarly temper.

HENRY NEUMANN.

Brooklyn Society for Ethical Culture.

NOTES AND COMMENTS

Compiled by
PAUL O. KOMORA
The National Committee for Mental Hygiene

A SYMPOSIUM ON MENTAL HEALTH

Plans are in the making for a Symposium on Mental Health to be presented before the Section on Medical Sciences of the American Association for the Advancement of Science at Richmond, Virginia, December 28–30, 1938. Collaborating in the enterprise are the American Psychiatric Association (an affiliated body of the A.A.A.S.), the United States Public Health Service, the Mental Hospital Survey Committee (composed of eight national medical bodies), The National Committee for Mental Hygiene, and a special committee of eminent psychiatrists who are developing the program for the symposium under the chairmanship of Dr. Walter L. Treadway, Assistant Surgeon-General of the Public Health Service in charge of mental-hygiene activities.

The symposium will provide an unusual opportunity to bring the great problem of mental health before the forum of the A.A.A.S. and, through it, to the scientific and lay public of America. Its object will be, essentially, to bring about a synthesis of our present knowledge of the problem in all its ramifications, to evaluate past experience, to crystallize aims and objectives, and to marshal the scientific forces of the nation for a concerted and coördinated attack on mental disorders and disease. It will be the first time in the history of American psychiatry and the mental-hygiene movement that the subject has received the special attention of this great scientific body as a major topic on its agenda.

The American Association for the Advancement of Science is the largest scientific society in the United States, if not in the world. Its active membership is over 19,000 and the memberships of its affiliated and associated societies (including duplicates) total around 750,000. The association has played a distinguished rôle in the promotion of science for ninety years, and through its 15 sections and 165 associated societies, it covers essentially the whole field of pure and applied science, offering at the same time exceptional opportunities and facilities for coördinating and integrating the various sciences. It holds two meetings each year, its annual meeting in the last week in December and another meeting in June. About 5,000

scientists usually attend the December meetings, and about half as many the June meetings. Its programs include, on the average, a thousand papers at each meeting, and notable symposia on broad fields of science are becoming more and more important features of these meetings.

The plan for the Symposium on Mental Health contemplates the holding of six sectional sessions over a three-day period, with an introductory exposition of the aims and scope of the symposium at the opening session, and a general presentation, summarizing the discussions, at a seventh, general session. The special sessions will be arranged and conducted under the leadership of section chairmen, who will secure advance contributions dealing with specific phases of the subject matter to be covered by each session.

This will involve the preparation of a series of papers, from seven to ten for each session, on as many topics, each paper running to not more than 3,500 words. These papers will not be read at the meeting, but will be published in advance of the meeting and used as a basis for discussion at the various sessions. They will be printed in a series of six brochures, one for each of the six sessions, each brochure containing all of the individual contributions to the particular session with which it deals. The papers embraced in each brochure will be summarized and critically analyzed by the section chairmen at their respective sessions, and then formally discussed by persons who will be selected by them and to whom the brochures will be distributed for study well in advance of the meeting. In addition, there will be an opportunity for general, open discussion at each session. All the discussions and summaries will be included, with the original contributions, in the published proceedings of the symposium, which will be issued and sold by the A.A.A.S.

This plan of advance publication of the papers has been adopted in order to make the most effective use of the symposium technique, and to insure a coördinated and integrated arrangement of the material to be presented. Such an arrangement, by allowing the fullest possible time for free discussion and interplay of thought, will, it is felt, make for the production of a publication of the highest scientific value.

The program will present a wide range of data, covering many phases of the mental-hygiene problem, but confined, as far as possible, to basic and fundamental issues. This will call for close collaboration between individual contributors and their section chairmen, in developing outlines and deciding upon the aspects of the field to be covered by their respective papers, which will then be edited, before use, to assure continuity, proportion, and unity of thematic treatment. These self-limiting requirements of the symposium method will

tend to eliminate discursive matter and to focus discussion on principles and considerations of primary importance.

The sectional headings are, provisionally, as follows: Mental Health Administration; Research in Psychiatry; Professional Education; Community Sources of Mental Disorders—Their Amelioration and Prevention; Physical, Cultural, and Social Environment in Relation to the Conservation of Mental Health; and Economic Aspects of Mental Disease. The contributions will aim, on the one hand, to bring out what is definitely known in regard to a particular problem, and on the other, to expose for discussion and study questions and issues that are in the forefront of present-day scientific thought in psychiatry and mental hygiene.

The session on research, for example, will show the present trends of thought, past accomplishments, and future possibilities in psychiatric research, and the most fruitful leads for investigation in this field. It will indicate, on the one hand, that the practical applications of psychiatry are quite in advance, and in some places perhaps running ahead, of the more strictly scientific developments in the subject; and, on the other hand, that there has accrued from research a large body of valuable, but widely scattered and unassimilated knowledge. This the symposium will attempt to bring together, organize, evaluate, and utilize in a more effective approach to the management and solution of the mental-disease problem. It will be the aim of this session, in short, to formulate the research problem in psychiatry and mental hygiene, and to provide a base line on which to build a comprehensive and unified program of scientific investigation, with a view to increasing public support of research in mental disease and to providing a guide for funds and foundations in subsidizing projects in this field in the years to come.

The session on mental-health administration will concern itself with the problem of developing more adequate measures and a wider and more equal distribution of facilities for the early recognition and treatment of mental disease. A glance at the present status of mental-health administration in the United States will show that no community, no state or local jurisdiction, has kept pace with the needs of the mentally ill. Rapid growth in population, coupled with the necessity for securing immediate institutional provisions for the more urgent cases, has resulted in the development of piecemeal facilities and policies, instead of an adequately balanced medical program to meet the needs. It is hoped that one result of the symposium will be an authoritative and comprehensive formulation of fundamental principles that may serve as a practical guide to state and local governments in developing sound, progressive, and more uniform policies and measures in the care and treatment of the mentally ill.

It is hoped that the symposium will develop new points of view that may with advantage be brought to bear upon the whole problem of the cure, control, and prevention of mental and nervous disorders, of all types and degrees. Dr. Treadway strikes the keynote of the symposium in the following statement:

> "It is high time that we mobilized all our scientific resources and explored all promising approaches, in order to realize the potential contributions inherent in the various scientific disciplines, within and without the field of psychiatry. The symposium, we feel, will illuminate the mental-health problem as never before and will lead to a new and better orientation for dealing with mental diseases and disorders, both as to treatment and as to prevention, in their personal and more general aspects."

Members of the program committee of the symposium, besides Chairman Treadway, are: Clarence M. Hincks, M.D., General Director, The National Committee for Mental Hygiene; Nolan D. C. Lewis, M.D., Director, New York State Psychiatric Institute and Hospital; Franklin G. Ebaugh, M.D., Director, Colorado Psychopathic Hospital; Harry Stack Sullivan, M.D., President, William Alanson White Psychiatric Foundation; Abraham Myerson,M.D., Director of Research, Boston State Hospital; Joseph Zubin, Ph.D., U. S. Public Health Service; Samuel W. Hamilton, M.D., Director, Mental Hospital Survey Committee; Grover Kempf, M.D., U. S. Public Health Service; Roscoe Hall, M.D., Clinical Director, St. Elizabeths Hospital; James S. Plant, Director, Essex County (N. J.) Juvenile Clinic; Malcolm H. Soule, Ph.D., Secretary, Section on Medical Sciences, A.A.A.S.; and Paul O. Komora, Associate Secretary, The National Committee for Mental Hygiene. Communications should be addressed to Symposium on Mental Health, American Association for the Advancement of Science, Room 822, 50 West 50th Street, New York City.

Tenth International Medical Congress on Psychotherapy

The Tenth Annual Congress of the International Medical Society of Psychotherapy will be held in England at Balliol College, Oxford, July 29–August 2, 1938. The congress will be under the chairmanship of Dr. C. G. Jung, who recently visited in America. Dr. Jung hopes for a large attendance from this country. The date of the congress has been especially selected in order to make it possible for it to be fitted into the programs of members of the United States visiting Europe, and the place has been chosen with the hope that the congenial surroundings of Balliol will provide a setting in which those personal and unofficial conferences and conversations can easily and spontaneously arise upon which the value of congresses of this

kind so largely depend. Endeavors will be made to provide opportunities before and after the conference for visitors to inspect any pieces of work in the country in which they are particularly interested. Americans intending to participate are requested to write early to Dr. E. B. Strauss, Hon. Secretary, 81 Harley Street, London, W.1. From Dr. Margaret Lowenfeld, Co-director of the London Institute of Child Psychology and a member of the committee on arrangements, comes this persuasive bid for a large delegation from the United States:

> "It had become clear at the last conference that while there were a number of points of view which were common to the Continental forms of approach, there were certain aspects of the work of psychotherapy as it is carried out in Anglo-Saxon countries which were peculiar to their own genius. The great democratic countries of the world have a contribution to make which is their own and which differs in vital and fundamental particulars from certain of the contributions made by other nations, and it is felt that at this time in the world's history a very real step forward could be made by this conference towards mutual international understanding. The growth of uniformity of opinion upon the Continent makes it particularly desirable for a weighty and adequate representation to be present at the conference, not only from Great Britain, the hostess country, but also from the United States of America."

Orthopsychiatrists Meet in Chicago

Child-guidance workers from various parts of the country assembled at the Hotel Stevens, in Chicago, February 24–26, to attend the Fifteenth Annual Meeting of the American Orthopsychiatric Association and to report the results of their researches on many phases of the study and treatment of juvenile conduct disorders and behavior problems. A variety of topics, new and old, engaged the attention of psychiatrists, psychologists, social workers, and other professional groups in general sessions, sectional meetings, and round tables, at which formally presented technical papers provided the major bases of discussion.

A substantial part of the program was given to the consideration of play therapy, its possibilities and limitations, several of the contributions revealing novel aspects of approach and technique in this now widely used form of diagnosis and treatment. A high light in this group of papers was one in which the group approach to shy and withdrawn children was described, the author reporting a transformation in attitude on the part of such children as a result of play therapy administered in a small farm camp. In the course of treatment, these children became aggressive in varying degrees, the problem for the staff, at the end of eight weeks, becoming one of dealing with a group of aggressive rather than recessive children! In the

process, improvements were noted also in neurotic symptoms, such as nocturnal enuresis, nail-biting, feeding problems, and so forth.

In a study of parental "acceptance" and "rejection," in which 31 "rejected" children were compared with 31 "accepted" children, it was found that the former were hyperactive, restless, lacking in stability, but aggressive and antagonistic toward society and showing delinquent trends; while the latter were calm, deliberate, coöperative, friendly, and stable emotionally. Rejecting fathers, as compared with accepting fathers, it was noted, tend to come from homes with dominating mothers, in which parents quarrel and the discipline of the children is harsh and inconsistent; while rejecting mothers, as compared with accepting mothers, have irritable mothers and dominating fathers, with much friction in the home, inconsistent discipline, and excessive punishment and criticism.

Discussion of "culture and personality" was carried over from a previous meeting of the association, those taking part in the discussion having been asked this year to report "observations concerning the specific relationship of personality factors to specific cultural influence," with special reference to the validity of the assumption, commonly accepted, that "in certain cultures certain personality features will occur more frequently than in others." As a point of departure the thesis was taken that the deeper unconscious layers (instinctual structure) of the personality are more uniform (*i.e.*, biologically predetermined), and that the cultural influences affect more the surface layers, which are shaped during post-natal development. More light was sought on the question as to the depth of cultural influences upon personality formation.

The following officers were elected to serve during 1938–1939: *President,* Dr. Frank J. O'Brien, Acting Director, Bureau of Child Guidance, Board of Education, New York City; *Vice-President,* Miss Almena Dawley, Chief Social Worker, Philadelphia Child Guidance Clinic, Philadelphia, Pa.; *Secretary,* Dr. Norvelle C. LaMar, Attending Psychiatrist, Payne Whitney Psychiatric Clinic, New York City; *Treasurer,* Dr. George S. Stevenson, Director, Division on Community Clinics, The National Committee for Mental Hygiene, New York.

The next annual meeting of the association will be held in New York City.

Commission on Graduate Medical Education

American medicine, ever alert to problems created by social and economic changes in the modern world and vigilant in the maintenance of high standards of medical training and practice, took another forward step with the formation recently of a Commission on Graduate Medical Education, to promote adequate educational pro-

grams and training facilities for general and special practitioners.

The commission is the creation of the Advisory Board for Medical Specialties, which was organized in 1933–34 for the purpose of coördinating graduate education and for the certification of medical specialists in the United States and Canada, and which functions in conjunction with the Council on Medical Education and Hospitals of the American Medical Association.

These groups, in coöperation with the various boards, of which the American Board of Psychiatry and Neurology is one of the more recent representatives, have established in general terms the basic requirements for proper training for the several specialties, and it is the objective of the Commission on Graduate Medical Education to develop programs "for actually putting these general standards into effect to meet the needs of the country."

The great need, according to a report on the subject published in the Bulletin of the American Academy of Ophthalmology and Otolaryngology (December 1937), is "the formulation of the educational problems and principles involved in the adequate training of specialists" and the creation of "methods whereby those in practice, general and limited, can keep abreast of new developments in diagnosis, treatment and prevention." The report points out that little attention has as yet been given to the opportunities for training for specialization of the large number of practitioners who are otherwise qualified and who desire to become fully equipped in a limited field of practice; that most of these men can leave their practice only for short periods; and that sound plans which will meet individual conditions and permit these physicians to secure an adequate preparation in a special field must be worked out. There is also the need of a better definition of interneship problems and the integration of hospital training with the undergraduate course, in order to make it more effective as a preparation either for general practice or advanced training for special practice.

The new commission was formed in recognition of the need for a study of the whole situation in graduate and postgraduate medical training and of the desirability of setting up a group "to mobilize the best current opinions and experience and to formulate principles and standards of training which may be of help in setting up programs of instruction."

At the organizing meeting of the commission, held at Chicago on December 4, at which policies and procedures were discussed, it was decided to project a three-year program of work, with an appropriate budget and with a full-time director of study. Dean Willard C. Rappleye, of Columbia University, is chairman of the commission, which is made up of twenty members, including representatives of

hospitals, universities, medical schools, licensing bodies, and the medical profession in general. Psychiatry is represented by Dr. Franklin G. Ebaugh, Director of the Colorado Psychopathic Hospital, and Director of the Division of Psychiatric Education of The National Committee for Mental Hygiene.

Josiah Macy, Jr., Foundation

Psychosomatic disorders and mental-hygiene problems associated with old age are receiving special attention in the researches and studies supported by the Josiah Macy, Jr., Foundation, New York, which recently published its first report since its establishment in 1930 by Mrs. Walter S. Ladd, with a fund of $5,000,000. In the six years covered by the report, the foundation made grants, ranging in amounts up to $16,000 and totaling $806,681, to 34 universities and 27 agencies in the United States, Belgium, Czechoslovakia, France, Germany, Hungary, The Netherlands, and Soviet Russia. Its program, the report states, is based on "the belief that a new foundation might wisely concentrate its interest upon those problems which have been most neglected under the increasing specialization of the sciences."

Declaring that "there is enough knowledge of health care to make a better world, but that it is not translated into social action," the report continues:

> "Medicine is faced with an opportunity and a responsibility for restating the problem of health and for developing methods for its conservation that will go far beyond the diagnosis and treatment of individual ills. Great progress in medicine was made possible in part by the social-economic developments which furnished ideas, facilities, and support for scientific research and its practical application; but these developments have themselves created new and urgent social tasks of health care which do not appear sufficiently recognized. Moreover, in medicine, as in engineering, large possibilities for advancement are obviously retarded by serious dislocations. Thus it is becoming increasingly necessary to view the problems of medicine in the light and context of a changing cultural setting."

The report asserts that study of the influence of emotion upon symptoms in organic disease has been neglected and needs encouragement, and that in seeking the origin of an illness, medicine can no longer overlook the possibility of emotional disturbances, nor in therapy ignore the emotional needs of patients. "As the pervasive rôle of emotion in health and disease is revealed," the report states, "there emerges a clearer realization of the interrelationships not only among organ systems, but also between the personality and the somatic processes in the total reactions of the organism. In this conception of psychosomatic processes is found a long-sought nexus be-

tween the social-cultural environment and the internal functional processes in man that make for health or disease, for recovery or death."

The report comments on the rapidly changing age distribution of the population in the United States, with its trend toward a predominantly older group, and on the mental-health aspects of the economic and social consequences of this change. The gradual elimination of the older worker from employment, it points out, "will give rise to emotional conditions which must find some release and, in an older group, they will probably be expressed in mental and psychosomatic disorders." The failure of the older individual to adjust under the newer conditions, and the attendant conflicts and tensions in family life, the report concludes, "emphasize the need for developing some way of life for the older individuals that will enable them to find enduring satisfaction and release, without damage to the lives of the children."

Illinois to Erect Neuropsychiatric Institute

The Department of Public Welfare of Illinois announces Governor Horner's approval of its general plans for a neurologic and psychiatric hospital and institute, to be located on the grounds of the Research and Educational hospitals in Chicago. We are indebted to Director A. L. Bowen, of the Department of Public Welfare, for the following account of this significant development:

> After the expenditure of some $25,000,000 upon new buildings and equipment at the various institutions in the Department of Public Welfare, which have provided adequate floor and air space for all the wards of the state, the department is taking advantage of a short breathing spell to erect what it regards as the capstone of its mental-hospital system.
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> Proceeding on the theory that all of the patients and inmates of its institutions, with few exceptions, represent neurologic or psychiatric disturbances, the department recognizes the necessity for such a center of research, study, and training for personnel in its mental hospitals, its prisons, its correctional schools, and its various divisions devoted to problem children, as well as mental defectives and border-line cases. Consequently, this new building will serve every branch and division of the department.
>
> A second departure from conventional lines in the construction of psychiatric hospitals is the inclusion of twenty-five beds for the use of the Institute for Juvenile Research. This agency will remain in its present buildings on the grounds of the Research and Educational hospitals, but will be connected with the new building where its hospitalization program will be carried out. The building will provide 100 beds for the psychiatric hospital, and 50 beds for the neurologic division, in addition to the 25 beds for the Institute for Juvenile Research—a total of 175 beds.

A third innovation is the invitation that the department has extended to the four medical schools of Illinois to use this institute and hospital for the training of their medical students in psychiatry, neurology, and all the behavior problems of children. The University of Illinois has accepted the offer, and some of the other medical schools have indicated their intention to do so.

Only the authority of the state can deprive an individual of his liberties. The Department of Public Welfare is organized to operate the mental hospitals in Illinois, and the courts are authorized to make their mental commitments to the department; consequently, this institute and hospital will always have at its disposal abundant material for study and treatment. The use of this facility by all of the medical schools will save them the cost of duplication of physical plant and personnel involved in their plans for teaching psychiatry and neurology. Details of the agreement for the use of the institute and hospital will be worked out by the time the building is ready for occupancy.

The building will include not only the facilities for teaching, and the hospital beds for special cases, but also such laboratories as may be needed and which the other parts of the Research and Educational group do not possess. The building will contain quarters for personnel and generous office space for members of the staff.

Impetus for the rapid completion of this project has been furnished by graphic illustrations of the growth of the welfare institutions of Illinois. On December 1, 1937, these institutions had a total enrollment of 51,958 as against 48,884 on December 1, 1936—a net increase of 3,074 in one year. The mental hospitals showed an increase in the year of 1,373; the two hospitals for the feebleminded, an increase of 263. The prisons of the state reported a population of 11,986.

Compared with the same date twenty-five years ago, the 1937 total represented a 100 per cent increase. If the same ratio should be maintained during the next twenty-five years, it will be necessary to duplicate the present institution plant, or double present capacity, with a proportionate increase in the burden upon the taxpayers' shoulders.

The general outlines of the new building and its cost are factors yet to be determined, but it is safe to say that it will have ample accommodations and will become the nerve center of all the state's forces in the fight on mental and nervous diseases.

The Malcolm A. Bliss Psychopathic Institute

Supplanting the old observation ward of the City General Hospital, construction was recently begun on a new psychopathic unit for the City of St. Louis—The Malcolm A. Bliss Psychopathic Institute. This unit will serve as a clearing house for psychiatric problems among those of the community unable to afford private care. It will also serve as a training and research center, with university connections, and will provide special facilities for children. Dr. F. M. Grogan, Superintendent of the St. Louis City Sanitarium, has kindly furnished the folowing description of the structural and functional lay-out of the institution.

The building, costing about $1,000,000, will be a six-story structure of red brick with stone trimming, and the general arrangement will conform with the "butterfly" design. Its Georgian style of architecture will harmonize with that of the City Hospital. The site on which the building is being erected is a two-and-a-half-acre tract immediately north of the City Hospital, which was purchased by the city for $109,800.

The ground floor will be occupied by the clinical laboratory and the departments of hydrotherapy and occupational therapy. On the first floor will be the administrative offices, offices of staff physicians, out-patient clinics, a lecture hall seating 150, offices and classrooms for the school of psychiatric nursing, the department of social service, the record room, and the staff library.

The second and third floors will be assigned to white patients and the fourth floor to colored patients. The total bed capacity will be 186, of which 142 will be for white and 44 for colored. There will be cafeterias for patients on the second, third, and fourth floors. On the fifth floor there will be an operating-room suite and residence quarters for the medical staff. Sun decks and all-weather loggias have been provided on the sixth floor and at the ends of some of the wings. The building will be connected with the City Hospital by two tunnels, one for passengers and the other for service transportation. The structure will be completed early in 1939.

The stay of patients will probably be limited to less than three weeks, during which time examination, observation, and study will be carried on and any necessary therapy administered. On each hall there will be offices of physicians and nurses and rooms for examination, consultation, and treatment.

In the belief that many individuals will be spared hospitalization by early diagnosis and treatment, two entire wings of the first floor have been allotted to an out-patient clinic. This clinic will be an integral part of the institution and, when necessary, will refer patients to the hospital proper. Convalescents and patients discharged from the hospital may there continue to receive necessary treatments. A large and active service is anticipated among both adults and children.

It is hoped much work will be done in preventive psychiatry and in the teaching of mental hygiene. A special effort was made to furnish separate quarters and adequate equipment for the examination and care of children, not only in the hospital proper, but in the out-patient clinic. Beds have been allotted in the hospital for twenty-four white children and eighteen colored. Half of the clinic will be devoted to child-guidance work, and psychological studies will be performed both in the hospital and in the children's portion of the clinic.

In charge of the institution will be a chief psychiatrist, and the personnel will include assistant psychiatrists, resident physicians and internes, a visiting and consulting staff, psychiatrically trained graduate nurses, psychiatrically trained social workers, a psychologist, a hydrotherapist, and occupational therapists.

Teaching facilities will be made available for the faculties and students both of the St. Louis University and of the Washington University School of Medicine, and for various schools of nursing and of social science in St. Louis. Provision has been made for research in the field of neurology and psychiatry, and considerable space has been desig-

nated for special clinical-laboratory investigations and for the Department of Records and Statistical Research.

Although originally planned as a separate institution, the new psychopathic institute will be served to a great extent by the various departments of the City Hospital. Heat, light, power, and laundry, as well as maintenance of building and equipment, will be provided by the City Hospital. The dietary department will prepare food and special diets for both patients and employees of the new institution. Supplies will be requisitioned and issued by the store room of the City Hospital. Most of the routine laboratory procedures will be performed in the laboratory department of the City Hospital. The City Hospital will furnish radiographic and dental service, none being provided in the new institution. There will be a close interrelationship between the visiting and resident staffs of both hospitals.

The institute will stand as a memorial to Dr. Malcolm A. Bliss, who died in 1934. For more than thirty years, Dr. Bliss gave unceasingly of his time and effort in behalf of the mentally afflicted throughout the state of Missouri. To him is due much credit for his constant endeavor to bring about improvement in the hospital care of mental patients. At the time of his death, Dr. Bliss was a member of the eleemosynary board of the state hospitals of Missouri, and held the position of consultant to the staffs of the City Hospital, of the St. Louis Training School, and of the City Sanitarium.

State Society News

California

The Northern California Society for Mental Hygiene was organized in San Francisco last fall, its tentative constitution and by-laws defining the purposes of the society as follows: To familiarize the public with the principles of mental hygiene; to focus the attention of the community upon existing mental-health problems and needs; to serve as a coördinating body for mental-hygiene activities in the community; and to work for the effective administration, as well as for the enactment, of such legislative measures as promote mental-health objectives. Dr. George S. Stevenson, of The National Committee for Mental Hygiene, attended the organizing meeting and spoke on the structure and functions of mental-hygiene societies and the programs and experience of state and local societies in other parts of the country.

The present organization is a revival of the California Society for Mental Hygiene, which was founded in 1915, but ceased to function in later years. The new name has been adopted to differentiate it from the Southern California Society for Mental Hygiene, which has been active for a number of years. Another meeting was held this spring to complete the work of organization and develop a plan of activity. The officers of the Northern California Society are: *President,* Dr. George S. Johnson; ***First Vice-President,*** Dr. Olga Bridg-

man; *Second Vice-President,* Mrs. Lovell Langstroth; *Secretary,* Miss Perle Dow; and *Treasurer,* Mr. Joseph Leo Hyman.

Connecticut

1938 is "Jubilee Year" for the Connecticut Society for Mental Hygiene, oldest of all mental-hygiene organizations, founded in 1908. The society is observing the anniversary by special regional programs, arranged in coöperation with each of its local committees, to be climaxed by a two-day institute on mental hygiene, which will be held in New Haven on May 6 and 7, with a fitting birthday celebration. Its thirtieth year finds the society active as never before, wrestling with the perennial problem of providing adequate care and treatment for the mentally ill and the mentally defective, stimulating clinic provisions and other community mental-health services for treatment and prevention, promoting local mental-hygiene organizations, and extending its educational work throughout the state.

A new undertaking especially worthy of note is its recently formulated plan for an organized attack on the problem of delinquency, through coördination of the legal, medical, educational, and social forces of the state in a coöperative five-year program of investigation and study looking to the adoption of practical measures to cope with the problem. As a preliminary step, the society is forming a "Master Committee," which will, in turn, create a series of subcommittees functioning through its various regional branches and including in their memberships representatives of the schools, social agencies, courts, recreational organizations, character-building agencies, and other groups whose work touches the problem of delinquency at any point.

Kansas

The Kansas Mental Hygiene Society will hold its annual meeting in Pittsburg on April 8 and 9. A strong program is promised, with two national leaders from outside the state, in addition to local speakers, and the attendance is expected to surpass that of the convention held at Wichita last spring, when 500 persons assembled from all parts of the state to participate in the proceedings. The topics of discussion will appeal to all types of workers and to laymen interested in any phase of the mental-hygiene movement, the emphasis this year being on the presentation of material which the non-technically trained can assimilate. Hence the conference is not primarily for psychiatrists, psychologists, and other professional groups, but is rather an effort to show how any worker with mental-health problems may come to have a better understanding of those problems and become better equipped to deal with them.

Louisiana

The Louisiana State Society for Mental Hygiene has had a very productive year since its organization last spring. Local units have been formed at Louisiana State University, Louisiana Normal College, Louisiana Polytechnical Institute (Ruston), and Centenary College, (Shreveport); and several parish (county) societies, as well as the New Orleans Mental Hygiene Association, have been established. The state society has a membership of about 300, and an active campaign to increase this membership is in progress. Nearly every part of the state and a great diversity of professions are represented. The state board of health, the department of public welfare, and the state medical society all are interested and actively coöperating in the society's work.

On the educational side, the society reports a number of achievements, among them four well-attended all-day mental-health conferences, at Louisiana State University, Louisiana Normal College, Loyola University, and the Louisiana Teachers' Association at Shreveport; a weekly mental-hygiene column in parish (county) newspapers throughout the state; and several radio talks. The society also issues a periodical news letter. The officers of the society are: *President,* Dr. Joseph A. O'Hara, President of the State Board of Health; *Treasurer,* Miss Suzie Lyons, Touro Infirmary, New Orleans; *Executive Secretary,* Dr. Paul C. Young, Louisiana State University.

Maryland

The Mental Hygiene Society of Maryland reports an increase in practically all phases of its work during 1937. Its major activity is the Baltimore Mental Hygiene Clinic, which served over 2,000 patients, mostly children, referred from more than 60 sources, during the past year; and this service has been extended to various counties of the state, in which clinics have been held with increasing frequency to meet local needs.

The educational activities of the society cover a wide range, from the training of physicians, medical students, nurses, school-teachers, and other professional workers, to public education aimed at strategic lay groups and community leaders. An effective aid in this connection is the recently re-organized lecture bureau, which furnishes speakers without charge. Seventy-two group lectures were given by the society's own staff to organizations of various kinds, and many more by the lecture bureau's staff. Plans are in progress for a large, two-day public conference on mental hygiene to be held on April 7 and 8.

The extension work of the society finds numerous outlets through

membership on various committees and agency boards, members of the staff having participated in 315 conferences and meetings during the past twelve months. An interesting example of coöperative relationships is its work with the Family Welfare Association, Southern District, whose staff members have met twice monthly with the society's clinic staff for a study of inter-agency relations, mutual problems, and cases, as a result of which plans for an experimental consultation service have been worked out for the ensuing year.

The work of the society is supported by the Community Fund and the University of Maryland, and through memberships. The staff is composed of two full-time and one half-time paid psychiatrists, two part-time volunteer psychiatrists, and four part-time physicians-in-training; one full-time psychologist; two full-time and one part-time psychiatric social workers and two workers-in-training; and two full-time and one part-time secretaries. Three of the workers are salaried personnel of the University of Maryland.

Massachusetts

Again exemplifying its leadership in the promotion of mental hygiene in the educational field, the Massachusetts Society for Mental Hygiene held a notable conference on "Mental Health in Education" in Boston on March 11 and 12, bringing to a focus the many-sided interests and activities of educators throughout the state in their bearing on the mental-health aspects of child training. Twenty-seven colleges and universities—practically all of the educational institutions in Massachusetts which offer courses for the training of teachers—joined with the society in sponsoring the conference, which dealt with various phases of education: nursery school and kindergarten, elementary education, junior and senior high schools, exceptional children and the college student, teachers colleges, and school administration. The program covered a wide range of topics, calling for 55 selected speakers, as well as general discussions, and necessitating the holding of simultaneous sessions by the seven sections of the conference, which drew a combined attendance of 1,200. It was the most successful of several meetings of its kind that the Massachusetts Society has conducted in past years and has undoubtedly brought nearer that fusing of sound educational philosophy and mental-health practice toward which the educator and the mental-hygienist are alike striving.

North Carolina

The North Carolina Mental Hygiene Society held its Second Annual Meeting at Durham on February 24, under the presidency of Ernest R. Groves, Ph.D., Research Professor at the University of North

Carolina. Between two and three hundred persons attended afternoon and evening sessions, which were devoted to a discussion of such topics as the contributions of academic psychiatry to mental hygiene, prevention of the common neuroses, and mental hygiene in relation to education and the home.

The society was organized in 1936 to capitalize the interest in mental health manifested increasingly in recent years by professional groups and representative citizens in various parts of the state. This interest found organized expression in the formation of the Charlotte Mental Hygiene Society in 1932, and the Durham-Orange County Mental Hygiene Society early in 1936, followed by the establishment of the state society in the fall of that year, with a view to coördinating local efforts and developing a unified state-wide program.

An accelerating factor in the growing interest in mental-health affairs was the notable survey made during 1936 by the North Carolina Commission for the Study of the Care of the Insane and Mental Defectives, which will provide material and stimulus for organized work in mental hygiene in the state for some time to come. Since then additional local units have been organized in Winston-Salem and Lenoir County (Kinston). Mental-hygiene clinics have been established by the Winston-Salem and Charlotte societies.

The present officers of the state society are: *President,* Dr. W. Raney Stanford; *Vice-President,* Dr. John S. Bradway, of Durham; and *Secretary-Treasurer,* Harry W. Crane, Ph.D., of Chapel Hill and Raleigh.

Alcohol . . . One Man's Meat . . .

Are You a Social Drinker? is the title of a sensible, instructive, and, we believe, helpful little pamphlet that we *know* will have a wide circulation, for reasons hereinafter mentioned. It was prepared by Dr. Edward A. Strecker, Professor of Psychiatry of the University of Pennsylvania, at the request of the Pennsylvania Liquor Control Board, as an aid in carrying out the injunction laid on it by law "to restrain the traffic in and use of" alcoholic beverages. This enlightened action by the director of public relations of the board strikes a new note in the long and checkered history of alcohol, and marks what is probably the first instance in the liquor industry in which profits are subordinated to the public good. The pamphlet will be wrapped around each bottle sold in the state stores, the only way in which spirituous beverages and wine can be purchased in bottles in Pennsylvania. In it Dr. Strecker discusses what he describes as "mental allergy to alcohol"—that is, the mental and emotional sensitiveness of many people to alcoholic liquor, just as certain individuals are physically sensitive to certain

foods. He points out danger signals and differentiates between safe drinking and dangerous drinking, and counsels those who imbibe to appraise their drinking habits by asking themselves four pointed questions, which we quote:

> 1. In your frank judgment, and in the honest opinion of your friends, is your behavior under the influence of alcohol such that it would tend to let you believe that you are one of those who should not use alcohol?
> 2. Consider the history of your drinking. Is it at about the same level of moderate, controlled drinking as it was in the beginning, or has it increased and assumed dangerous proportions?
> 3. What do you gain by drinking? Is that gain something upon which you are dependent or could you manage your life satisfactorily without it?
> 4. Are you sure that you could stop drinking if you wanted to stop?

"An Invitation to Read"

A new note in child guidance is sounded in *An Invitation to Read,* an eighty-page pamphlet prepared by a special committee appointed by Mayor F. H. LaGuardia to select suitable books for the use of juvenile delinquents whose cases are before the Children's Court of New York City.

The pamphlet contains an annotated list of 277 titles chosen after a survey and study of the entire field of literature for children and youth, as part of a carefully thought out plan to meet the needs of varying reading abilities and levels of maturity among boys and girls from six to eighteen years of age, with a view to encouraging their interest in good books and the cultivation of reading habits as an aid to social adjustment.

The list is classified and graded according to school age groupings and subject matter, the selections covering a wide range and variety of books suited to all types of interest and appeal, including fiction and non-fiction, picture books, fairy tales, realistic stories, poetry, general information, and books on sports, outdoor life, mechanics, and adventure. It is not an all-inclusive, but a representative, balanced list, the authors including many of the famous names of literature, classic and contemporary, and many not so well known.

The committee that selected the books (a psychiatrist, two children's librarians, a school librarian, a civic librarian, a teacher of English, and two judges of the Children's Court) recognizes the limitations of the project as a socially therapeutic measure and its subordinate place in any program for the reduction of juvenile delinquency, but rightly points out its potential values and possibilities, when taken in conjunction with other more fundamental approaches, as a means of helping children develop interests and habits of conduct

that will lead them away from conflict with the law and toward socially approved behavior and a happier way of life.

The committee recommends that a complete collection of the books listed be purchased and installed in the Children's Court in a place where they will be conveniently accessible to the children awaiting disposition of their cases. It also suggests the appointment of an experienced children's librarian to guide the children in their reading and to assist the judges and probation officers in suggesting books for the individual child.

Wisely the committee adds that the child should be encouraged, as far as possible, to make his or her own selections. In this connection the descriptive annotations, the subject index, and the title and author index which accompany the list will be of practical help, both to the court personnel and to the children. As the committee points out, the method of interesting the child in reading and the conditioning effects of the court atmosphere in initiating him into the world of books will be important factors in the favorable or unfavorable results. Understanding the type of book to place in a particular child's hands is extremely important, and its value, as a means of helping children who are having social difficulties, cannot be overestimated.

The presence of reading disabilities is also recognized as an important conditioning factor, and the committee suggests how reading difficulties may be dealt with in promoting the child's contact with books, since a reading disability may well be an underlying cause of school failure and resultant delinquency. The recommendation is made that the Children's Courts obtain from the schools the intelligence quotient and reading-ability records of each child before the courts.

Mental-hygienists will watch this experiment with interest. "Bibliotherapy," as psychiatrists call it, has been taken up as an aspect of treatment in a number of hospitals for the mentally ill in recent years, and its adoption as a measure of social therapy in the management of juvenile conduct disorders may well prove of lasting benefit in the development of community resources to cope with the complex problem of delinquency and crime. Certainly the project is worth an investment of $390—the cost of the entire list of 277 books which the Mayor's Committee urges the Children's Court to buy for this purpose.

An Invitation to Read is, indeed, an inviting, well-organized, and attractively printed report. It is put out for wide distribution, at 25 cents a copy, by the Municipal Reference Library, 2230 Municipal Building, New York City. It is thus available to children's

courts, probation workers, educators, librarians, and child psychologists in other cities interested in this pioneer effort and, perhaps, in setting up similar experiments in dealing with their own child problems.

Dr. Frank J. O'Brien, Acting Director of the Bureau of Child Guidance of the Board of Education, is chairman of the committee, which will continue its work in an advisory capacity to the Children's Court. Other members of the committee are: Dr. Stella S. Center, of the Board of Examiners; Claude G. Leland, of the Bureau of Libraries; Rebecca B. Rankin, of the Municipal Reference Library; Irene Smith, of the Brooklyn Public Library; Harriet S. Wright, of the New York Public Library; and Justices Jacob Panken and Rosalie L. Whitney, of the Children's Court.

1936 Census of Mental Patients

The Federal Census Bureau reports an increase of 12,303 resident patients in mental hospitals during the year 1936. According to a bulletin released by the bureau on January 19, 1938, which summarizes its latest annual census, there were 432,290 patients in hospitals for mental disease in the United States on December 31, 1936, and 52,125 patients on parole. Of the resident patients, 364,403 were in 174 state hospitals; 34,902 in 68 county and city hospitals; 21,960 in 25 U. S. Veterans' hospitals; and 11,025 in 199 private hospitals. A total of 468 hospitals were covered in the report. There were a total of 109,076 new admissions to all mental hospitals; of these, 19,839 were classed as dementia praecox; 12,775 as manic-depressive; 10,954 as psychoses with cerebral arteriosclerosis; 7,561 as general paresis; and 5,281 as alcoholic psychoses.

Menninger Clinic Continuing Postgraduate Courses

The medical staff of the Menninger Clinic will conduct its fourth annual postgraduate course on "Neuropsychiatry in General Practice," April 25 to 30, inclusive, at the Menninger Clinic, Topeka, Kansas. The course this year will include a brief introduction to the fields of neurology and psychiatry and a specific application of this knowledge to the large group of cases of psychoneuroses, psychoses, and psychogenic and neurological disorders which every physician meets in his daily practice. Child-guidance problems in general practice will be considered. Suggestions made by those who took the course last year have been embodied in this year's program in order to make it applicable to the most common practical problems of the physician. As in previous years, several guest

speakers, prominent in the fields of neurology and psychiatry, will appear at the evening sessions of the course.

Back Copy of "Mental Hygiene" Wanted

A request has come in from a public library for a copy of the October, 1917, issue of Mental Hygiene. If any reader has a copy of this issue that he does not care to keep, we would appreciate it very much if he would send it in to The National Committee for Mental Hygiene, 50 West 50th Street, New York City.

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